S. Hrg. 100-572

EXAMINING THE MEDICARE PART B PREMIUM INCREASE

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDREDTH CONGRESS

SECOND SESSION

WASHINGTON, DC

NOVEMBER 2, 1987

Serial No. 100-14

Printed for the use of the Special Committee on Aging

U.S. GOVERNMENT PRINTING OFFICE
83-915 WASHINGTON : 1988

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

S141-7

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EXAMINING THE MEDICARE PART B PREMIUM INCREASE

MONDAY, NOVEMBER 2, 1987

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The committee met, pursuant to notice, at 10:12 a.m., in room 268, Dirksen Senate Office Building, Hon. John Melcher (chairman of the committee) presiding.

Present: Senators Melcher, Heinz, Shelby, Pressler, Cohen, Domenici, and Chiles.

Staff present: Max I. Richtman, staff director; Holly Bode, professional staff member; Kelli Pronovost, hearing clerk; Larry Atkins, minority staff director; and Nancy Smith, professional staff member.

OPENING STATEMENT BY SENATOR JOHN MELCHER, CHAIRMAN

The CHAIRMAN. The committee will come to order.

This morning we are going to hear from witnesses who are going to explain how the increase in Medicare Part B costs will affect older Americans. The increase will be $6.90 per month as recommended and determined by the Administration, and will be effective January 1st, 1988, just a few months off. This increase, added to the $17.90 monthly premium paid in 1987 brings the total cost each month for older Americans on Medicare Part B to $24.80 per month.

We have to keep in mind what the effect of this increase will be on those people who are on fixed incomes, who are struggling to pay all their bills.

We have had a great deal of mail lately in the Senate Special Committee on Aging on this issue. Many of these letters reflect the alarm of people clear across the country. I am going to read you one or two excerpts as samples of those comments.

"I am writing about the increase in Medicare payments. I have also already received another increase from Blue Cross. Please see what you men can do about this. I am writing this for myself and my other 'oldies.'" That's from Mrs. Antonucci of Warren, Michigan.

Another says, "I am furious that Medicare premiums are going up a great deal again. My husband is totally disabled and we live on Social Security. If you haven't tried it you don't know how difficult it can be."

This hearing is scheduled today to look at the increase from two standpoints: The standpoint of Congress because we're responsible—we said the administration determined the increase in the monthly premium, but it's Congress that is responsible. We've had studies to determine what is happening in Part B and what is happening to cause the constant increase, most notably a 1986 Office of Technology Assessment report entitled "Payment for Physician Services: Strategies for Medicare." That report outlined four different options. The first is reform of the present fee-for-service system.

The second is payment based on fee schedules; which would be developed using a relative value scale. A relative value scale gives each service a weight, which would be multiplied by a conversion factor, stated in dollars.

The third option is payment for packages of related services, which is similar to the DRG's in the hospital setting. Reimbursement would be for a "bundle" of services based on the diagnosis.

The fourth option is capitation. That's a plan in which an insurance company or some other entity contracts with a Health Maintenance Organization or with a group of physicians, to provide all services to Medicare beneficiaries for a fixed amount per year.

Well, those are the four primary options that we have to consider. We have asked for studies and we have had those studies. I think it's time now that Congress does something about it, and selects a plan that is fair and decent. I think that's all older Americans are asking of Congress: Do something that is fair, do something that is reasonable, but do it now. Maybe through the help of this particular hearing this morning we can arrive at some conclusions that those of us who serve on this committee can recommend to our colleagues in the Senate. Well, here's something that is fair; here's something that is decent for people on Medicare, and then go with it.

Senator Cohen, can we hear from you?

[The prepared statement of Senator Melcher follows:]

OPENING STATEMENT OF SENATOR JOHN MELCHER

Good morning. On behalf of my colleagues on the Special Committee on Aging, I'd like to welcome everyone to this morning's hearing on the reasons for and impact of next year's scheduled unprecedented increase in the Medicare Part B premium.

On September 30, the Health Care Financing Administration officially advised us that the Part B premium would have to be increased next January by 38.5 percent, from its current level of $17.90 to $24.80 per month. Over the last several weeks, I have heard from hundreds of seniors throughout the nation who are frightened and angry about the prospect of this increase. These folks include:

> Mrs. N. of California writes, "Why can't the elderly have the bare necessities. We are near destitute."
>
> Mrs. C. of Missouri writes, "I am furious. * * * My husband is totally disabled and we live on Social Security. If you haven't tried it, you don't know how difficult it can be."
>
> Mrs. H. of Texas writes, "We cannot afford the extra premiums. Our Social Security checks are small and our medicine bills are high. Instead of giving millions to the Contras, let's put that money into the Medicare program to help U.S. elderly citizens."

It is easy to understand why these people are concerned. One day, they learn that their Part B premium is going to shoot up by 38.5 percent, and the next day they read that they will receive an appreciated but smaller 4.2 percent cost-of-living adjustment. Just recently they heard that they will pay for the entire costs of the catastrophic health care legislation that we passed last Tuesday.

Older Americans are not free-loaders—they want to pay their fair share. They also want to be able to pay for the vitally needed health care coverage that Medicare Part B provides and the type of protection that would be provided under the catastrophic health care bill. However, these individuals, particularly those who are living on low and fixed incomes, are starting to feel a bit overwhelmed. They don't want to be forced into making the decision of choosing between paying for necessities like utilities or rent or groceries and needed Part B protection. However, they feel that is the direction we are heading with these premium increases. If this hearing serves no other purpose, I want to make certain that before we adjourn today, we will have received a number of realistic recommendations that will help us assure Medicare beneficiaries that this kind of increase will never occur again.

To that end, today I am releasing a staff report which outlines the many issues related to the Medicare Part B program and summarizes the options available to address the problems that have contributed to the burdensome Part B premium increase. Key findings from this report include:

(1) Part B enrollee out-of-pocket costs have increased 211 percent since 1973.

(2) 24 percent of total Medicare outlay in fiscal year 1986 were for physicians' services and it is projected that this will increase to 27 percent in fiscal year 1988.

(3) The Health Care Financing Administration reports that 60 percent of this year's $6.90 Part B premium increase is due to growth in reimbursement to physicians.

I look forward to the testimony of today's witnesses. I am confident that they all will shed light on the Part B premium increase issue. This issue is of utmost importance to our elderly and to the Members of this Committee.

STATEMENT BY SENATOR WILLIAM COHEN

Senator COHEN. Thank you, Mr. Chairman. I appreciate having the opportunity to attend this hearing.

I think that the demographics are of our society marching in a rather clear direction—that we are aging as a population. We are living longer, thanks to medicine and science. We require, therefore, more treatment and more medication and accordingly, medical costs are inevitably going to rise. I think that there are several questions that we have to address today.

Number one, are the increased costs of physician services provided under Medicare in fact legitimate? Or are they exploitative and unnecessary?

Number two, who should pay the costs?

And number three, how much should be paid?

Those are the three essential questions that we have to address, Mr. Chairman, and I look forward to hearing from the witnesses and to addressing these questions in a responsible and fair-minded fashion.

The CHAIRMAN. Thank you, Senator Cohen.

Senator Pressler?

STATEMENT BY SENATOR LARRY PRESSLER

Senator PRESSLER. Thank you, Mr. Chairman.

I think it's very important that we hold this hearing on the 38.5 percent increase in the Medicare Part B premium. First of all, it should be explained that this has nothing to do with the recently passed catastrophic illness legislation. This is an increase due to rising health care costs and greater demands on the Medicare Part B program.

Let me say that I think one solution, in terms of the cost of health care, is finding a way to lessen the number of lawsuits against doctors and medical institutions. If we could put a cap on some of the recoveries, particularly for punitive damages—or indeed, change the nature of punitive damages, perhaps overall health care costs could be reduced; currently punitive damages are usually insured, and just add to insurance premiums. Furthermore, no one is punished for an obvious wrongdoing.

Another area we have to look at is the number of tests that are required. Recently, I had a public listening meeting in Mitchell, South Dakota at which a woman in her late 60's stood up and said very publicly that during a recent spell of illness in which she was hospitalized, she was given a pregnancy test. Doctors present said that it was required as part of standard procedures. If doctors don't do all these tests, they might be sued if something goes wrong, or be accused of not doing all the tests available.

My point is, there are many costs associated with medical care that are not necessarily the doctors' fault or the hospitals' fault, but the fault of some Federal regulations and requirements of our legal system. I think that when we examine overall health care costs in this country, not only for senior citizens but for all age groups of our people, we must find ways to come to grips with these areas—the number of lawsuits, lack of arbitration, high punitive damages which are seldom ever paid by doctors but by insurance companies, and how these factors affect everyone.

Mr. Chairman, I want to compliment you on holding this hearing. During the next 3 or 4 years, I believe we are going to find that senior citizens are shocked at how much Medicare is increasing in cost. The 38.5 percent Medicare Part B increase, which is to be implemented on January 1, 1988, does not reflect expansions in the program. It does not include coverage for catastrophic illnesses, which should become law in a few months. Catastrophic coverage will cost senior citizens even more. This drastic increase comes from expanded costs, too many required tests, too much bureaucracy, and generally increased costs in the delivery of health care in our country.

Senior citizens, particularly those who rely on Social Security as their sole source of income, cannot cope with these rapidly rising costs of medical care. A 38.5 percent increase is very harsh medicine for the elderly to swallow, and I hope that this hearing identifies many solutions today, in addition to those that I have suggested.

The CHAIRMAN. Thank you, Senator Pressler.

Senator Shelby?

STATEMENT BY SENATOR RICHARD SHELBY

Senator SHELBY. Thank you, Mr. Chairman.

With the inception of the Medicare program back in 1966, the Part B premium—also known as the Medicare Supplementary Medical Insurance, SMI, program—cost just $3. Well, since that time the expansion of the program, the growth in the number of participants, and the consistent increases in the cost of health care in this country have dictated a substantial rise in the cost of the

Part B premium to $24.80 per month—21 years later, almost $22 more. It's that simple. Or is it?

Mr. Chairman, our concern and interest in the problems associated with the high cost of health care for the elderly in this country have led us to examine, under your guidance, many ways of trying to make the system work better for the health care providers, for the Government, and—most importantly—for the beneficiary. Just last week we witnessed the broadest expansion of the Medicare system to date, an expansion that will safeguard the elderly against catastrophic cost of a serious illness.

It is with a great deal of pride that I count myself a member of a committee that has had such a significant role in the shaping of the Senate-passed version of the catastrophic protection bill. This was due largely to the excellent committee leadership of Senator Melcher and the bipartisan nature that characterizes the working relationships and interaction among the members of this committee.

This morning we have gathered here to discuss the Part B premium which helps pay for the costs of physicians' services, physical therapy, diagnostic and x-ray services, and durable medical equipment and other services. As I mentioned earlier, there are several components that would necessitate the expected increases in the Part B premium to date. Interestingly, however, the greatest increase in the premium prior to the most recent announcement was an increase of $2.40 for calendar years 1984 and 1985, and then again in 1985 and 1986, which leads us to wonder how this year the adjustment, a 38.5 percent increase, can be a figure of $6.90.

Of course, there are several factors governing the increase in the Part B premium. From what I understand, the Part B program is financed by enrollee premiums, income generated from general revenues, and the interest earned from the SMI trust fund's assets. Among other factors figured into the formula for the increased premium, apparently cost projections for fiscal year 1987 were inaccurate, thereby incurring expenses in excess of the projections. In addition, according to HCFA, however, the greatest percentage of increase in the premium is due to physician expenditures.

As our discussion today turns toward the reasons for this unprecedented increase, I know first and foremost in all of our minds will be the financial effect that this higher premium will have on the beneficiaries. Above and beyond the effect to the beneficiary, I am here to try to discover—with the assistance of our distinguished and very knowledgeable witnesses—the answer to a seemingly simple question: How can we prevent an increase of this magnitude from occurring again? Or can we?

As we have attempted to safeguard the elderly against the high cost of catastrophic illness, so too we must look into controlling Part B program costs to ensure that this coverage is not priced out of reach for a significant number of low-income beneficiaries.

The **Chairman**. Thank you, Senator Shelby.

I want to announce that there is a paper that has been prepared by the committee staff, an overview of the issues concerning Part B Medicare program.[1] That's available now, and any of you who care to have it will find it on the press tables. You can pick up a copy before you leave.

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[1] See appendix, p. 125 .

Senator Heinz?

STATEMENT BY SENATOR JOHN HEINZ

Senator HEINZ. Mr. Chairman, thank you very much. I too want to hear from Dr. Roper and our other witnesses. We are all here because we are deeply concerned about the 40 percent increase in the monthly Part B premium.

I am inclined to believe that the large Part B premium increase in this one year is a mistake, and it's a mistake for three reasons. First, the jump from roughly $18 to $25 will put a dent in the budget of some very hard-pressed senior citizens at a time when they will have difficulty affording it. Second, the increase would not appear to be their fault. I think HCFA has to bear part of the blame for mismanagement of the trust funds. If they had predicted program costs better and kept a cushion in trust funds we wouldn't need this large increase. Third, and I hope we can get into this even more, the premium increase strikes me as a flag of surrender to rapidly-rising medical costs that threaten to overwhelm older Americans.

As I analyze the numbers behind the Part B increase, well over half of the scheduled increase—$3.90—is totally man-made. By "man-made," I mean the result of HCFA's errors and misjudgments. And $1.50 of this is a result of HCFA's decisions over the years about building and depleting contingency reserves that have led to unnecessary fluctuations in the Part B premium. Certainly, one of HCFA's objectives should be to manage the trust funds to avoid a large jump in the premium. The remaining $2.40 of the so-called "man-made" share is the result of errors HCFA made in projecting 1987 costs. These man-made errors are of the type that could be and should be avoided in the future if we are to relate the premium more directly to the program's costs.

Finally there is the underlying reason for most of the rise in the premium this year, the rise in physician reimbursements under Part B. Over 61 percent of the increase in projected 1988 expenditures under Part B can be explained by outlays for physician services alone. The fact is that the elderly are being asked to pay more and more each year for the medical care they receive because there are no limits on what we are willing to pay physicians.

We will hear a lot of differing opinions today about why the costs of Part B Medicare are rising so rapidly. Some will argue that there are more older people in need of care and using care. Others will argue that the elderly are using more outpatient and physician services because Medicare has cut back on hospital reimbursement. Finally, some will argue that physicians are charging us more for the same services.

We desperately need to get to the bottom of this problem and determine what is causing the increase in Part B costs. We need to sort out how much of it is paying for better care for more people and how much of it is simply price increases for the same services. Finally, we need to make sure that we can control what we spend for medical care without interfering in the physician's decisions about good patient care or reducing the quality of care that our senior citizens receive.

This last issue in my mind, Mr. Chairman, is the most critical challenge to all of us as practitioners, policy-makers, or regulators. We have already put beneficiaries at risk for rising Part B costs; we must not also put them at risk for poor quality or too little care. Nor should we put the responsibility for deciding what is and is not effective and efficient physician practice on the patient's shoulders.

I look forward to learning from our witnesses today what can be responsibly done to control the costs of the Part B premium.

Thank you, Mr. Chairman.

[The prepared statements of Senator Heinz, Glenn, and Bradley follow:]

OPENING STATEMENT OF SENATOR JOHN HEINZ

In September HCFA startled us all by announcing a one-time increase of almost 40 percent in the monthly premium older Americans must pay for their medical insurance under part B of the Medicare Program. This large an increase in the part B Premium in 1 year is a mistake. It is a mistake for three reasons. First, the jump from almost $18 to almost $25 a month in premiums will put a dent in the budgets of many older Americans at a time when they can ill afford it. Second, the increase is not their fault—HCFA must bear part of the blame for mismanagement of the trust funds—if they had predicted program costs better and kept a cushion in the trust funds we wouldn't need this large an increase. Third, the premium increase is a flag of surrender to rapidly rising medical costs that threaten to overwhelm older Americans.

As I analyze the numbers behind the part B increase, well over half of the scheduled increase—$3.90—is totally "man-made". By "man-made" I mean the result of HCFA's errors and misjudgments; $1.50 of this a result of HCFA's decisions over the years about building and depleting contingency reserves that have led to unnecessary fluctuations in the part B Premium. Certainly, one of HCFA's objectives should be to manage the trust funds to avoid a large jump in the premium. The remaining $2.40 of the "man-made" share is the result of errors HCFA made in projecting 1987 costs. These "man-made" errors are the type that could be and should be avoided in the future if we are to relate the premium more directly to the program's costs.

Finally, there is the underlying reason for most of the rise in the premium this year—The rise in Physician Reimbursements under part B. Over 71 percent of the increase in projected 1988 expenditures under part B can be explained by outlays for physician services alone. The fact is, the elderly are being asked to pay more and more each year for the medical care they receive, because there are no limits on what we are willing to pay physicians.

We will hear a lot of differing opinions today about why the costs of Medicare part B are rising so rapidly. Some will argue that there are more older people in need of care and using care. Others will argue that the elderly are using more outpatient and physician services because medicare has cut back on hospital reimbursement. Finally, some will argue that physicians are charging us more for the same services.

We need desperately to get to the bottom of this problem and determine what is causing the increase in part B costs. We need to sort out how much of it is paying for better care for more people and how much of it is simply price increase for the same services. And finally, we need to make sure that we can control what we spend for medical care without interfering in the physician's decisions about good patient care or reducing the quality of care that our senior citizens receive.

This last issue is, in my mind, the most critical challenge to all of us as practictioners, policymakers and regulators. We have already put beneficiaries at risk for rising part B costs; we must not also put them at risk for poor quality or too little care. Nor should we put the responsibility of deciding what is and is not "effective and efficient" physician practice on the patient's shoulders. I look forward to learning from our distinguished witnesses today what can responsibly be done to control the part B Premium.

STATEMENT OF SENATOR JOHN GLENN

Mr. Chairman, like you I am very concerned about the administration's announcement that the Medicare Part B premium will increase from $17.90 per month to $24.80 per month on January 1, 1988. This unprecedented 38.5 percent increase—the largest in the program's history—will have a devastating impact on many Medicare beneficiaries who are already burdened by high out-of-pocket health care costs.

During the past several years, Congress has made major changes in the Medicare program. Implementation of the prospective payment system (PPS), based on diagnosis-related groups, has shifted some care out of hospitals, thus moving the burden of payment from Part A to Part B. Physicians' fees were frozen for several years, but there is concern about the increased volume and intensity of services physicians are providing. And questions are being asked about the management of the Part B Trust Fund because of the spend-down of the contingency reserve.

I believe that the information provided by today's witnesses will be very helpful to all Members of Congress as we consider further changes in the Medicare program. We need to know how beneficiaries are faring under the program; we need accurate information about the causes of rapidly rising Part B expenditures; and we need to know what options are available to improve the program.

Mr. Chairman, I look forward to hearing from today's witnesses and thank them for their participation.

STATEMENT OF SENATOR BILL BRADLEY

Mr. Chairman, I was deeply concerned when the Administration announced last month that the Medicare Part B Premium will increase on January 1 from $17.90 to $24.80 a month. This 38 percent increase is by far the largest in the history of the Medicare program. I applaud the Chairman for holding this hearing so that we can learn more about this problem. And I hope that Congress can take whatever actions are necessary to ensure that increases of this magnitude do not happen again.

I understand that there are three main reasons why the increase is as large as it is: First, about twenty percent of the increase is because Medicare Part B trust fund reserves have been depleted to the point that they are now almost all gone. All future spending must be paid for with future revenues, rather than trust fund reserves. Secondly, over thirty percent of the increase is needed because we underestimated the money to pay for 1987 Medicare expenses. Physician expenditures increased 12 percent faster than had been projected last year. We have already spent that money. And finally, the remaining 40 percent of the increase is to cover next year's projected increase in physician reimbursements. The Health Care Financing Administration's actuarial estimates show Part B expenses increasing 14 percent next year—that is three to four times the overall inflation rate.

These are staggering increases. I know that some of the rise in federal health care costs is due to the increases in the number of elderly Americans. And some is due to the fact that an increasing proportion of our older Americans are much older—over 85 years of age—and therefore have longer, more severe illnesses. But demographic trends explain only a very small part of the increase in spending. Much of the increase is due to expensive advancements in medical technology, which allow the elderly to lead long lives and to additional money paid to physicians for treatment.

Mr. Chairman, the increase in the Medicare premium deeply troubles me. If we were witnessing a one-time aberration in the premium, I would not be so concerned; but it seems to me that we are witnessing a spiral in costs that—left unattended—will never get under control. I hope that the witnesses at this hearing—both representatives of the elderly and the health care professionals—will give us some sense of the dimensions of the problem and the possible long-term solutions.

The CHAIRMAN. Thank you, Senator Heinz.

Now we will hear from our witnesses. I want to say at the outset that we have seven witnesses. The first witness is Dr. William Roper, Administrator, Health Care Financing Administration, and I think all of us here on this committee are used to hearing this word "HCFA." But I don't know how many older Americans are aware that when we say "HCFA" we're not hiccuping, we're referring to the Health Care Financing Administration. And Dr. Roper, as its Administrator, is here to tell us how HCFA arrived at this increase of $6.90.

Dr. Roper.

STATEMENT OF WILLIAM L. ROPER, M.D., ADMINISTRATOR, HEALTH CARE FINANCING ADMINISTRATION

Dr. ROPER. Good morning, Mr. Chairman, members of the committee. I am pleased to have the chance to speak with you this morning. I will summarize my statement.

As you said at the outset, we are here to talk about the 38.5 percent increase in the Part B premium and the underlying problem, which is the all-too-rapid escalation in costs of the Part B program of Medicare. Come January 1st, the premium will be set at $24.80 a month, a rise of $6.90 over the current premium of $17.90.

As you know, Mr. Chairman, Medicare has two parts. Part A is hospital insurance and Part B is the Supplementary Medical Insurance. Today we are talking about Part B, which is financed by the premium and by general revenues of the Government. When Medicare was first passed, the two parts financing Part B, premium and general revenue, were set so that each would finance one-half the cost of the program. But in 1976 Congress made the decision to limit the increase in the premium from year to year by the Social Security cost of living adjustment percentage. That had the effect of holding down the amount of the premium, since the costs of the program rose at 17 percent per year and the COLA rose only 7 percent per year. So by fiscal year 1983 the premium only accounted for 25 percent of the cost of the program. That year, the Congress moved to halt further erosion in the amount of the program financed by the premium, and set in law that the premium would make up 25 percent of program costs for calendar years 1984 through 1988. We have published a notice in the Federal Register dated September 30, that sets forth the premium that will recoup 25 percent of the cost of the program. In calendar year 1989 and thereafter, the increase in the premium will again be limited by the cost of living adjustment. That will have the effect of keeping down the amount of the premium.

We are proposing—and we believe it's prudent that you consider, as the Finance Committee has—making permanent the present requirement that premiums finance 25 percent of the cost of the program. In addition, we are proposing that the premium be set at a higher level for new enrollees in the program.

Let me explain to you the reasons for this 38.5 percent increase. This is a $2 further increase above what we had forecast in the President's 1988 budget. The increase comes about because of three factors.

First, our earlier projections for fiscal year 1987 spending under Part B were too low. The program is growing more rapidly than we had predicted a year ago. Also, we project that it's going to grow rapidly in 1988 and beyond.

Finally, we drew down the contingency fund that caused the premium to be lower than it would otherwise have been—because a surplus had built up in the Part B trust fund.

Growth in program expenditures accounts for 78 percent of the increase in the Part B premium. I think it's important to stress that the underlying cause of this increase in the premium is overwhelmingly the growth in program expenditures, and that's where I hope the Congress will focus its attention for the future. Indeed, the contingency fund draw-down does account for some of the increase, but I take issue with Senator Heinz' characterization of this as "mismanagement." What we have done is spent a surplus in the trust fund, and that has had the effect of causing the premium to be lower than it would otherwise have been for 1986 and 1987. We believe that was a prudent step, in the best interest of beneficiaries. What we are now seeing is a catch-up because of two years of having the premium be lower than it would otherwise have been. We could have opted for a more rapid catch-up of the contingency fund but we have chosen to do this in a gradual fashion—again, because we believe that's in the best interest of beneficiaries.

Decisions about whether and how much to draw down or build up the contingency fund in each year affect only the timing of the impact of increases in Part B costs. Again I stress, though, that the important focus of attention is on the underlying growth in Part B spending.

Part B spending is attributable primarily to spending for physician and other medical services, and that's where we have devoted our attention for the last two months in seeking ways to keep this increase from being so large in the future. We believe that over half of this growth in physician spending is for increases on a per-enrollee basis, in the utilization of services, the volume of services, changes in the mix or intensity of services, changes in technology, and so on. In sum, my point is it's not so much increases in prices per units of service but rather in the number and kinds of units of service.

This increase in utilization of services is much more difficult to restrain because it requires looking over the shoulder of America's doctors, so to speak, and making judgments about whether, on a case-by-case basis, those units of service were indeed in the interest of beneficiaries and were necessary.

Let me turn finally to what we believe to be the reasonable options for dealing with this rapid, dramatic increase in Part B spending and the increase in the Part B premium. Over the long term we believe that the best solution is moving toward greater reliance on private health plans which have a capitation payment feature. These plans bundle together the services that are offered to beneficiaries and delegate to these plans substantial authority over decisions about how much to pay individual doctors and hospitals and how to make sure that their use of services is necessary and appropriate. We believe that that sort of decentralization in the health care system is much better than us trying to make centralized decisions for 31 million beneficiaries, 500,000 doctors, and 6,000 hospitals across the country.

Enrolling Medicare beneficiaries in private health plans is a concept in which Senator Heinz has had a leadership role. It was through his good efforts in 1982 that the TEFRA legislation allowed us to offer this option to beneficiaries, and we appreciate his and others' efforts to foster the growth of such plans in the Medicare program. We currently have a million of our 31 million beneficiaries enrolled in such private health plans today. We would like to expand these plans so that people over 65 have the same range of choices as people under 65 for their health care benefits.

Unfortunately, we feel somewhat frustrated by recent actions of the Congress. Last year's Reconciliation Act raised concerns about certain physician incentive payment arrangements within these private plans; that has had the effect of raising substantial doubt in the HMO community about the Federal Government's intention of moving ahead in this area. We hope that shortly this area will be clarified through a study that our Department is doing.

Also, the House in their reconciliation language this year would severely curtail our ability to move ahead with certain demonstrations of private health plan arrangements within the Medicare program. I am pleased that the Senate Finance Committee, on the other hand, specifically authorizes the Secretary to conduct such demonstrations. But it is unrealistic—over the near term, at least—to put all our faith in capitation arrangements for restraining the growth in Part B spending. We believe it's important to apply some pressure on the fee-for-service system. There our options include limiting the amount we pay per fee; that is, price controls within the Medicare program in Part B. We have in fact recommended that the amount that fees are allowed to go up be limited for all except primary care services.

A second option available to us is to provide more intensive claims review, looking over individual claims to judge whether services are rendered appropriately, whether they should have been rendered at all, to eliminate unnecessary services. We are seeking additional funding for this "utilization review," as it is called, in our contractor budget.

A third option is to bundle services together and to pay a fixed price based on average costs—some sort of DRG alternative.

And finally, an alternative that we are working on intensively at the moment is directing beneficiaries to preferred providers—doctors and others who practice a conservative style of medicine and who agree to more intensive review of their practice patterns—based on financial incentives to beneficiaries. I believe that is a hopeful alternative that we are working on for possible inclusion in the President's 1989 budget.

In conclusion, let me say that the growth in Part B spending, while rapid of late, has been large over the two decades of the program. Controlling the rapid growth in the Part B program is a problem that plagued the Congress and the Administration under both parties. We seek to work with you and your colleagues in the Congress to deal with this problem in a way that's best for beneficiaries and best for all concerned with the Medicare program.

Thank you.

[The prepared statement of Dr. Roper follows:]

STATEMENT OF

WILLIAM L. ROPER, M.D.

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

Mr. Chairman and Members of the committee. I am pleased to be here today to discuss the Medicare Part B premium for 1988 and the all too rapid escalation in Part B costs. On September 30, 1987, we are publishing a notice announcing the premium in the Federal Register. As you are aware, the notice sets the premium for next year at $24.80, an increase of $6.90 over the current premium of $17.90.

Background

I would like to begin by placing this year's increase in its historical context. Since its inception, Medicare has been composed of two parts; Part A, the Hospital Insurance program, which principally covers inpatient hospital services, and Part B, the Supplementary Medical Insurance program, which covers physician and other outpatient services. Part A is financed through mandatory payroll deductions, while Part B, a voluntary program, is financed from two sources: a monthly premium paid by beneficiaries and general revenues.

For the first nine years of the program, beneficiaries and the Federal government contributed equally to finance the Part B program. Beginning in 1976, however, legislation required that the premium be set at the lower of one-half of projected Part B costs (for the aged beneficiary) for the next year, or last year's premium increased by the cost of living adjustment, or COLA, given to Social Security beneficiaries. Between FY 1975 and FY 1983, Part B outlays grew 255 percent, or 17.2 percent annually. During the same period, the Social Security COLA increased benefits by 81 percent in total, or 7.7 percent annually. Since Part B costs grew more than three times as fast as Social Security benefits, and since the Part B premium increase was restrained by the COLA, the share of Part B costs borne by beneficiaries through premium payments fell from 50 percent to around 24.8 percent for FY 1983.

In response, Congress moved to halt further erosion of premium payments by requiring that the premium cover 25 percent of estimated Part B program outlays for calendar years 1984 to 1988. Over this period, the premium has grown about 14.2 percent annually (almost 70 percent), from $14.60 for calendar year 1984, to the current 1988 premium of $24.80. Over the same period, program costs have increased at the same rate.

In 1989 and thereafter, under current law, premiums will again be limited by the cost of living increase. Since we expect Part B outlays to grow at least 66 percent over the next 5 years, or 2.6 times as fast as the COLA, we estimate that, by 1993, the Part B premium will only finance 17 percent of Part B aged outlays. The Administration has proposed making permanent, for current enrollees, the present requirement that premiums finance 25 percent of costs. In addition, the premium would be set at a higher level for all other enrollees. Maintaining the premium at 25 percent of program costs for all enrollees alone would reduce the Federal deficit by $1 billion in FY 1989 and by $6 billion over three years (FY 1989 to FY 1991).

Methodology for Setting the Premium

For calendar years 1984 through 1988, the Medicare statute requires the Secretary to promulgate a premium based on a monthly actuarial rate equal to one-half of the total benefits and administrative costs which are estimated to be payable for Part B services to enrollees aged 65 and over. In calculating the monthly actuarial rate, the Secretary is required to include an appropriate amount for a contingency margin for the Part B trust fund.

Explanation of the 1988 premium increase

In 1988, the monthly Part B premium will increase to $24.80, an increase of $6.90 or 38.5 percent over the current premium of $17.90. In the President's FY 1988 budget, we had projected a 1988 premium of $22.80. Faster program growth, however, necessitates a higher premium.

Three factors explain the $6.90 increase: adjusting prior years' spending estimates that proved too low accounts for 35 percent of the increase; projected spending increases from 1987 to 1988 account for 43 percent; and the draw-down on the contingency in 1987 contributes roughly 22 percent. (See Table 1) I would like to elaborate on these findings presently.

As noted, growth in program expenditures contributes 78 percent of the increase in the 1988 Part B premium. This translates into $5.40 of the $6.90 increase, and the $5.40 can be broken down into two pieces: spending in 1987 that exceeds projections, and projected spending increases from 1987 to 1988.

Our projections of 1987 expenditures at the time the 1987 premium was promulgated were nearly 11 percent lower than our current estimates of spending for 1987. Were we to recalculate the 1987 premium based on current estimates, it would be $2.40 higher than it actually is. This difference accounts for 13.4 percentage points of the 38.5 percent increase in the premium for 1988. Increases in physician spending alone account for over 90 percent of these 13.4 percentage points.

Totally apart from those unanticipated increases in costs in 1987 are expected increases in costs in 1988. Current actuarial estimates show an increase in Part B spending of 13.9 percent for 1988. This growth accounts for $3.00 of the $6.90 increase in the 1988 premium, or 16.7 percentage points of the 38.5 percent increase. Physician spending is responsible for the lion's share -- 63 percent -- of that 16.7 percentage point increase.

In summary, for both the unanticipated increase in Part B spending in 1987, and the projected increase in Part B spending in 1988, growth in expenditures for physicians' services constitutes the bulk of the increase. Increases in physician spending explain $4.05, or nearly 60 percent of the $6.90 jump in the 1988 premium.

Effects arising from the contingency fund constitute the remaining 22 percent of the increase, or $1.50 of the $6.90 increase. The Part B contingency is essentially equal to the cash balance of the trust fund net of charges for services that have already been provided but which have not yet been paid. The purpose of the contingency is to maintain reserves adequate to cover unexpected events or circumstances. In addition to the contingency, there is a built-in cushion in the trust fund due to the time lags between both the provision of a service and when a bill is sent to our contractor, and receipt of a bill and actual payment. The Part B contingency need not be terribly large, or even positive, given the built-in cash float and the fact that the financing of the trust fund is adjusted annually when the premium is promulgated. In fact, the contingency in this premium promulgation is negative.

The actuaries believe that a contingency equal to approximately 3.5 percent of the following year's incurred expenditures is the optimum level. However, given the volatility of the trust fund expenditures, the optimal level serves only as a target. In some years the contingency is larger than 3.5 percent, in other years smaller. In either case, our policy has been to move in the direction of the optimal level, usually over the course of a number of years, in order to minimize dramatic swings in the premium.

At the end of 1984, the contingency reserve for Part B exceeded the adequate level. Net assets totalled $6.3 billion. (Table 2) Consistent with our approach of correcting surpluses and deficits over a period of years, premium rates were set at levels intended to spread or amortize the 1984 surplus over the years 1985 through 1987. In each of these years, to reduce the reserve to the appropriate level, the Part B premium promulgated by HCFA was lower than the amount that would have been necessary to finance 25 percent of incurred expenditures because of the draw down from the contingency reserve. Had we not spent from the reserve in these three years, the premiums would have been higher by $0.64 in 1985, $0.83 in 1986, and $1.43 in 1987, before rounding.

Thus, if we had not reduced the 1987 premium by drawing on the contingency reserve, the increase in the 1988 premium would have been less dramatic, and we also could have drawn on the higher reserves to reduce the 1988 premium increase further. However, we expect that approach to the 1987 premium would have laid us open to criticism that we were charging an unjustifiably high premium, given the large contingency reserve at that time. When the 1987 premium was promulgated a year ago, we were projecting net trust fund assets of about $ 7.7 billion at the end of 1985, $5.1 billion at the end of 1986 and $3.2 billion at the end of 1987.

Based on more recent data, we now know that our spending projections for last year were too low and that the trust fund balance was therefore reduced somewhat more than intended. Moreover, the contingency reserve will be negative at the end of 1987 and 1988. However, given the cash float, the trust fund will be able to maintain payments. The actuaries estimate that the cash balance at the end of 1988 will be sufficient to finance an additional 1.7 months of trust fund outlays.

Although, the trust fund will be able to continue to make payments with the negative contingency. this is clearly not the optimal way to finance the trust fund. We could have opted to rebuild the contingency to the optimal level in one year. This would have required, however, that the premium increase be approximately $2.00 higher. Given the $6.90 increase already planned, this option was not viable. Therefore, we again decided to move the contingency back toward the optimal level over a number of years. The premium we have established for 1988 includes 6.5 cents to prevent further reduction in the contingency. Including the effect of the $1.43 reduction in the contingency in the 1987 premium, the total contribution of the contingency policy to the 1988 premium increase is $1.50, or 8.4 percentage points of the 38.5 percent increase.

While the Part B contingency policy bears on the year-to-year changes in the premium, it does not affect the total premiums paid by beneficiaries over a number of years. Decisions about whether and how much to draw down or build up the contingency fund in each year affect only the timing of the impact of increases in Part B costs.

The important point is that the Part B premium in the years 1984 through 1988 is driven by growth in Part B costs, not by our policy on the contingency fund. The annual rate of increase in the premium between 1984 and 1988 is 14.2 percent, consistent with the 14.4 percent annual rate of growth in incurred Part B spending per enrollee benefits during that period. To speak figuratively, then, increases in Part B costs are the engine in the premium machine. To have lower premiums, we need to control the growth in program expenditures.

Increases in Physician and Other Part B Spending

Part B spending is attributable primarily to spending for physician and other medical services (76 percent) and hospital outpatient services (20 percent). Group practice prepayment plans and other services account for the remainder of Part B spending. Physicians' services comprise about 85 percent of the physician and other medical services category. (Other medical services include durable medical equipment, ambulance services, laboratory services, etc.). Thus, physicians' services, representing about 65 percent of total Part B payments, effectively drive Part B spending.

Historically, Medicare physician spending has increased very rapidly, particularly relative to growth in the general economy, as measured by the Gross National Product (GNP). Between FY 1975 and FY 1983, it increased 342 percent or at a compound annual rate of 19.7 percent. The GNP increased about one-third this much (113 percent or at a compound annual rate of 9.9 percent) during this period.

This growth produced commensurate increases in physicians' incomes. According to the annual Medical Economics survey of physicians, median net physician income grew 30.8 percent between 1981 and 1986. The CPI grew by 20.6 percent in the same period.

The long-term growth trend in Medicare physician spending slowed somewhat between fiscal years 1984 and 1986, when the hospital prospective payment system was implemented and the 22-month freeze on physician fees (30 months for non-participating physicians) was in effect. Medicare physician spending increased only 24.6 percent during these years, or at a compound annual rate of 11.6 percent. Notwithstanding the Medicare fee freezes, this was still double the growth in the GNP. Thus, the persistent high rate of increase Medicare expenditures for physician services continues to pose a problem.

The national health expenditures data series offers further insight into the Medicare physician spending phenomenon. The data show that Medicare physician spending is increasing faster than non-Medicare physician spending. Between 1980 and 1986, Medicare physician spending increased 60 percent more than non-Medicare physician spending [141 percent versus 88 percent] and more than two and a half times as much as the GNP [54 percent]. As a result, the share of the physician market attributable to Medicare payments increased 22.5 percent, from 16.9 percent in 1980 to 20.7 percent in 1986. This figure compares to an increase of only 11.7 percent in the beneficiary population over this period.

What is causing the overall 13.5 percent per aged enrollee increase in Medicare physician spending? We believe that over half is due to what we call the residual category, which includes increases on a per enrollee basis in the utilization or volume of services; changes in the mix or intensity of services; and changes in technology and new services or benefits. Increases in the utilization of services include increases in the volume of services such as ambulatory visits, and lab and radiology tests, as well as fragmentation of services, producing an increase in the number of bills for a given service or bundle of services. Changes in the mix or intensity of services include both real and reported changes in services (e.g., new and more complicated services as well as upcoded services).

It is not at all clear that these increases in utilization have improved the quality of medical care. The research of John Wennberg and Philip Caper on practice patterns indicates that wide variations in practice patterns exist without producing clinically meaningful differences in health outcome. HCFA's research agenda with regard to practice variations is very active. In particular, the RAND practice pattern study is finding that many procedures are performed for inappropriate indicators.

It has been suggested that physician and other Part B costs are increasing because an increasing percentage of Medicare beneficiaries are using sufficient services to exceed the deductible. The value of the annual Part B deductible, which has stayed at $75 since 1982, is eroding due to inflation, with the result that more beneficiaries meet it. Nevertheless, very little of the increase in Part B costs can be attributed to this factor. Between fiscal years 1982 and 1986, the percentage of aged Medicare enrollees whose spending for Part B services exceeded the deductible increased by 2.5 percentage points per year from 67.9 to 77.8. The increase in Part B expenditures attributable to beneficiaries who cross the deductible threshold due to its declining real value is minimal because the amount by which they exceed the deductible is very small.

Another hypothesis holds that increases in Part B spending are due, in part, to a shift in the delivery site of services from inpatient to outpatient settings, as a consequence of the hospital prospective payment system or the activity of Peer Review Organizations. This movement would cause a shift from Part A to Part B, resulting in a greater rate of increase in Part B outlays. This hypothesis, however, contributes little to explaining the growth in Part B spending. Although spending for hospital outpatient department facility services is increasing, this sector is too small a piece of the whole to explain the increases in either physician or total Part B expenditures that we are observing. Considering physician payments, the bulk of physician services does not vary according to the site of service (i.e., hospital inpatient setting vs. hospital outpatient department vs. physician office), shifts of services from inpatient to outpatient settings should not much affect physician spending. In fact, it has been argued that the shift toward outpatient settings might be slowing growth in physician spending if, for example, physicians perform fewer consultations and lab tests here, as some speculate they do. The redistribution from Part A to Part B of costs associated with facility services and non-physician services such as laboratory tests is also too small to explain the high growth in Part B spending.

The aging of the Medicare population has also been offered as a possible explanation for the growth in Part B outlays. However, this factor will contribute very little to projected increases in Part B spending in 1988. In fact, it is estimated that it will account for only 60 cents of the projected $118.17 increase in part B benefits per aged beneficiary for the year ending June 30, 1988. This amounts to $17 million of the projected increase of $3.9 billion of incurred benefits for the elderly during that period.

Understanding the specific components of the increases in the utilization of services is a difficult undertaking for several reasons. In the past few years we have devoted significant resources to developing a new Part B data base, known as the Part B Medicare Annual Data System, or BMAD. Our goal in developing this system is, precisely, to be able to understand and describe characteristics of Medicare payments to physicians and other Part B providers. Unfortunately, our efforts to develop comparative historical data have been hampered by the lack of a common procedure terminology and coding system across carriers, prior to 1984-1985. Time lags between the actual provision of services and the accumulation of complete data for the time period in which those services were furnished also complicate analysis. Additionally, the magnitude of the claims volume processed by carriers -- projected to be 367 million claims in FY 1988 or 1.4 million per working day -- presents a formidable task. Finally, carrier claims processing systems vary and this leads to differences in the way information from bills are processed and stored and to inconsistencies in national comparative data.

To understand what is causing the increase in Medicare physician spending, HCFA has funded cooperative agreements with the Center for Health Economics involving 10 states from 1983 to 1988. The researchers will disaggregate the components of the increase. However, no results are expected before early 1988 and full results will be available in mid 1990.

Our research and demonstrations grants solicitation, published on September 10 in the Federal Register emphasizes our major commitment to better understanding characteristics of and trends in physician payment, and identifying recommendations for changes in Medicare physician payment policy.

Options

The dramatic increase in the premium for 1988 is perhaps most productively viewed as a symptom of the continuing high rate of growth in Part B costs. To control these increases effectively over the long term, it will be necessary to address both price and utilization.

We believe that capitation approaches offer the greatest promise for successful long-term reform of the Medicare payment system. By placing the determination of globally bundled payments, decisions regarding fee levels, utilization review, use of preferred provider networks, and adoption of incentive systems to encourage appropriate care in the hands of plan administrators. Each plan can approach these issues as it deems best. Encouraging a variety of private health plan options also offers beneficiaries choices and opportunities for expanded benefit packages.

For these reasons, the Administration is pursuing as a long-term policy goal greater availability to Medicare beneficiaries of pre-paid health care options. To further the availability of private health plan options to Medicare beneficiaries, the Secretary has proposed legislation that would enable HCFA to enter into risk contracts with employers and unions, permitting these entities to combine their supplemental benefits with the Medicare benefit, for their Medicare-eligible retirees and annuitants. Such arrangements would pave the way for employers and unions to rationalize and perhaps enrich the health coverage they provide, and would allow their retirees and annuitants to come on to the Medicare rolls without disruption of their existing relationships and routines with health care providers. The Department has also planned demonstrations of this concept, generally called the MIG or Medicare Insured Group demonstrations.

We have been frustrated in our efforts to test and proceed with these ideas, which we believe have important potential, by several recent actions in the Congress. The Omnibus Budget Reconciliation Act of 1986 included a provision prohibiting physician incentive plans which, when it takes effect January 1, may seriously impair the ability of HMOs and CMPs to structure incentive arrangements that encourage physicians to reduce inappropriate utilization. The prohibition may undermine the viability of HMO/CMP risk contracts, effectively denying senior citizens the benefits of this important feature of the Medicare program.

In addition, House reconciliation language for FY 1988, if enacted, would severely curtail our ability to move ahead with MIG demonstrations. These restrictions slow our progress toward greater control over physician and Part B spending, even as we struggle together to solve this problem. I am pleased to note however, the Senate Finance Committee reconciliation package specifically authorizes the Secretary to conduct such demonstrations. We hope this position will prevail in Conference.

We recognize that it is unrealistic to expect our private health plan strategy to change the profile of the Medicare program in the near term, making capitation the predominant mode of health services delivery and reimbursement. Therefore, we believe it is important to apply some pressure on the fee-for-service system. While each suffers from limitations, we have identified four broad conceptual approaches to controlling escalating costs in this environment:

- limit payment fees;
- provide intensive claims review to eliminate unnecessary services;
- bundle services and pay a fixed price based on averages; or
- direct beneficiaries to preferred provider networks that exclude providers with inappropriate practice patterns.

Limit payment fees. HCFA strongly supports steps to remedy situations where Medicare reasonable charges are overpriced. Last year we proposed reductions for cataract surgery which were incorporated in the Omnibus Budget Reconciliation Act of 1986. We strongly support the actions taken in the FY 1988 reconciliation bills to reduce payment for certain overpriced procedures. HCFA has a strong program of operational reviews of selected procedures, research on identification of overpriced procedures and research to develop a relative value scale (RVS) system.

Nevertheless, we are pessimistic that an RVS system will effect meaningful large-scale reform of physician payment or successfully control spending in this area. Such an approach may improve perceptions of equity among physicians. However, past experience tells us that physicians will respond to price reductions or payment redistributions that will occur under an RVS system by increasing volume, perhaps leaving us in a worse situation than we are in now.

Intensive claims review to validate medical necessity and appropriateness of the level of care can greatly reduce payment for unnecessary services and cut program costs. In FY 1988, we propose to expand our carrier medical review activities by about 40 percent to over $74 million. These activities will save the Part B program almost $520 million, a return of better than seven to one. But clearly there are limits to this approach imposed by system capacities and perceptions of arbitrariness by beneficiaries and providers.

Bundled payments and fixed prices based on averages represent another option to achieving Medicare payment reform. By establishing a fixed prospective payment, this approach would increase incentives to provide only medically necessary and appropriate services, similar to incentives operating in the successful hospital DRG system.

The President's budget for FY 1988 included a proposal to bundle payments for radiology, anesthesiology and pathology (RAP) services into a single payment amount for hospital-based physicians' services. This approach recognizes the unique relationships that physicians providing RAP services have with hospitals and patients. Traditionally, these physicians maintain a hospital-based practice and have a contractual arrangement or other close relationship to the hospital. Their relationships with individual patients are distinctive from those of attending physicians in several ways: usually, the patient has no opportunity to select these physicians, their services are dependent upon the attending physician's orders or decision for surgery, and their care for the patient ends with discharge. These factors make a DRG-based payment for RAP services more feasible and advisable than one for all inpatient services.

Preferred provider networks. Increasingly, the private sector is making use of preferred provider networks, or PPOs, to direct beneficiaries to selected providers. Plan administrators enroll providers that offer high quality care at favorable prices. Provider performance is assessed through intensified utilization review and poor performers are excluded from the network. Perhaps the PPO approach could be used effectively to make changes in Medicare. We could contract with PPO administrators, possibly existing carriers, to organize and manage Medicare PPOs in their areas. Through the operation of utilization review and financial incentives, the program might bring needed pressure to bear on volume and level of intensity of services, resulting in more appropriate utilization and patterns of service.

Issues to be considered in developing a Medicare PPO include: how beneficiaries could be encouraged to use the PPO providers, whether expected patient volume and other incentives would be sufficient to attract providers to join the network, and whether efficacious utilization profiles could be developed to weed out providers of inappropriate care.

As the members of this Committee know well, getting a handle on the rapid growth of the Part B program is a problem that has plagued the Congress and both Republican and Democratic administrations since the beginning of the program (except during the Economic Stabilization Program of 1971-1973). There are no easy or quick solutions. Although we prefer the reforms we have proposed, the Administration supports savings provisions that slow the growth rate in Medicare Part B spending such as freezes on physician payment for non-primary care services. Such provisions would help slow future beneficiary premium hikes and future jumps in the Federal deficit from soaring Medicare Part B costs.

I want to emphasize today that I recognize the importance of this problem. I am committed to working with you to find acceptable and effective ways to control the rapidly escalating Part B costs that are placing an unacceptable burden on beneficiaries and on the Federal budget.

Table 1

COMPONENTS OF INCREASE IN 1988 PART B PREMIUM FROM $17.90 TO $24.80

Total increase in premium	($6.90; 100%)		38.5%
Correction for prior projections	($2.40; 35%)		13.4%
Physicians' reasonable charges		12.1%	
Group practice prepayment plans		2.2%	
Other categories		-0.9%	
Program growth, 1987-88	($3.00; 43%)		16.7%
Physicians' reasonable charges		10.6%	
Outpatient hospital & other institutions		4.3%	
Group practice prepayment plans		1.3%	
Independent lab		0.5%	
Home health agencies		0.0%	
Contingency reserve	($1.50; 22%)		8.4%
Completion of spend-down		8.0%	
Build-up for 1988		0.4%	

TABLE 2
Actuarial Status of the SMI Trust Fund
1967-1988
(Dollar Amounts in millions)

	CASH (CY)		INCURRED	
	Balance in trust fund	Excess Ratio /1 (in months)	Excess of assets over liabilities	Incurred Ratio /2
		As of June 30,		
1966	122	1.12		
1967	412	2.90	77	0.048
1968	421	2.45	(104)	-0.053
1969	199	1.08	(238)	-0.111
1970	188	0.95	(497)	-0.212
1971	450	2.07	(323)	-0.127
1972	643	2.71	(161)	-0.057
1973	1,111	3.58	(64)	-0.018
1974	1,506	3.82	244	0.056
1975	1,444	3.08	270	0.051
1976	1,799	3.32	(3)	0.000
1977	3,099	4.80	627	0.084
1978	4,400	5.70	1,770	0.201
'979	4,902	5.23	2,483	0.235
980	4,530	3.88	1,768	0.139
1981	5,877	4.35	788	0.054
1982	6,230	3.94	2,783	0.158
1983	7,070	4.13	3,988	0.200
		As of December, 31		
1984	9,698	4.87	6,297	0.265
1985	10,924	4.80	7,624	0.272
1986	8,291	3.10	3,185	0.096
*1987	4,793	1.56	(1,494)	-0.039
*1988	6,184	1.75	(1,417)	-0.033

* Projected.

/1 Number of months of Trust Fund outlays that could be financed by end of year cash balance.

/2 Ratio of assets less liabilities at the end of the year to total incurred expenditures for the following year.

SOURCE: 1987 Annual Report of the Board of the Trustees of the Federal Supplementary Medical Insurance Trust Fund.

The CHAIRMAN. Thank you, Dr. Roper.

You say that your preference is capitation and state that close to one million of the 32 million older Americans on Medicare are under capitation under some plan. That's only about 3 percent.

Dr. ROPER. Indeed.

The CHAIRMAN. I can see that it would relieve you and perhaps a lot of people—Congress, too—from a lot of headache if capitation costs came in at a figure that was less than would be the case without it. Have you got some indication that that will indeed be the case if capitation were pursued?

Dr. ROPER. Let me begin, Mr. Chairman, by saying that my embracing the idea of capitation with a private health plan option in Medicare, as we prefer to call it, is based not on a cost savings but rather because I believe it's in the best interest of doctors, hospitals and beneficiaries for us to decentralize decision-making and allow these private plans to make those judgments instead of us making them here centrally.

The CHAIRMAN. Well, I would certainly agree with that because I've looked at some of the headaches of paperwork and computer work that is involved with getting a payment out of Medicare.

Dr. ROPER. But let me get to the point of your question——

The CHAIRMAN. It would claim to relieve you of all of that, but haven't you created a sort of a monster within this computer framework of how many slots there are, how many different types of x-rays covering almost the same type of diagnostic procedure, and how many different tests are available that you're willing to pay for if the physician is willing to order them?

Dr. ROPER. The current system of traditional Medicare is very complicated, as you say. That's a basic reason for wanting to move in this direction to the private health plans.

The CHAIRMAN. But haven't you created that monster yourself?

Dr. ROPER. No, sir.

The CHAIRMAN. Who has created it?

Dr. ROPER. Well, that's the way the health care system has evolved. And under the traditional Medicare program we pay bills under the Part B payment system the way private insurers pay their bills——

The CHAIRMAN. So the insurance companies have done it to us?

Dr. ROPER. Well, I'm not pointing fingers anywhere——

The CHAIRMAN. Well, I want to find out because Congress or the Administration or somebody has done it to us, and I'd like to know whether you are partly guilty.

Dr. ROPER. I am sure we're partly guilty.

The CHAIRMAN. All right. We'll start from there.

How much are you guilty?

Dr. ROPER. Let me answer that by——

The CHAIRMAN. You can't be just partially pregnant. How much are you guilty?

Dr. ROPER. We are equally guilty.

The CHAIRMAN. Equal with whom? Who are you equal with, Doctor, in this guilt?

Dr. ROPER. I think we have a system that is driven by beneficiaries' legitimate desires for better health care services——

The CHAIRMAN. I've never gotten a complaint yet that said that, "You know, when I went to my physician the other day, he wouldn't take all those tests that I was hoping he would take." I've never had that complaint.

Dr. ROPER. Secondly, it's driven by physicians who are changing the way they practice medicine——

The CHAIRMAN. Isn't it driven partially by the fact that sometimes we've held down fees for physicians and they made up some of that by some tests?

Dr. ROPER. Sure. We have had price freezes in the past and that has led, quite understandably, to physician's changing behavior what was not frozen, that is, the number of units of service delivered.

The CHAIRMAN. Can we untangle that?

Dr. ROPER. Yes, sir. And that's the point for bundling services together under a capitation arrangement. And you asked me——

The CHAIRMAN. Now, wait a minute. You've got two different options. One of the options we have is bundling similar to DRG's in hospitals. Is that of much value for us to consider?

Dr. ROPER. It's not my favorite proposal. I'll put it that way.

The CHAIRMAN. The thing that bothers me about capitation, I don't know how we get a capitation plan in Forsyth, Montana—that just happens to be my home town—I don't know how that would work in rural America. I don't know—as a matter of fact, I don't know how a couple who are retired and on Part B Medicare who are completely satisfied with their physician services, how they would get into a capitation program. That's the part that bothers me. I think capitation is rather a large organization, isn't it? We can't modify that to make it real small groups, can we?

Dr. ROPER. Well, I think it is easier for these plans to set up in urban areas. Increased enrollment in private health plans will come incrementally. While we're awaiting that it's important for us to do what else I addressed in my testimony, and that is to apply the oversight that we already are, but to a greater extent, to look at individual claims and judge whether or not they are for appropriate services, appropriately rendered.

Further, we are looking to move in the direction of selecting conservative practitioners of quality medicine and steering a larger volume of patients to those practitioners.

The CHAIRMAN. Well, I think it might be confusing, what you mean by "conservative practitioners." I think a lot of people might think that's some sort of Republican position. [Laughter.]

Why don't you tell us what you mean by "conservative"?

Dr. ROPER. What I mean by that, sir, is people who do not overutilize services inappropriately.

The CHAIRMAN. All right. That means a physician that is only going to order a test or an x-ray because he thinks it's absolutely essential to that particular day or for this particular patient. Is that what you're saying?

Dr. ROPER. A physician who orders the things that are necessary for quality medicine.

The CHAIRMAN. In other words, you mean a physician who has asked for less tests and less x-rays?

Dr. ROPER. Who has not overutilized, yes.

The **Chairman**. Well, I've taken enough of your time, Doctor. I think we should allow these other Senators some time.

Senator Heinz.

Senator **Heinz**. Mr. Chairman, I'd be happy to go next, but are you going by the early bird rule, or by courtesy? [Laughter.]

The **Chairman**. I guess under the early bird rule I should recognize Senator Cohen.

Senator Domenici, do you have an opening statement you want to make?

Senator **Domenici**. No, I'll do it all at once. [Laughter.]

Senator **Cohen**. Doctor Roper, I'd like to just follow up on the last question.

If the Medicare Program directs beneficiaries to the more cost-conscious physicians, would you have a situation in which physicians who hold down the services that they provide would reduce the quality of care? Would you run the risk that by directing more patients to those physicians who are more conservative, you thereby increase their volume, and thereby run the risk of decreasing the quality of the medical care they provide?

Dr. **Roper**. To be clear, our desire would be not simply to encourage patients to go to cheap doctors, but to good practitioners of quality of medicine but who are careful practitioners.

Senator **Cohen**. How do you determine that?

Dr. **Roper**. In general, the private plans that are now doing this, and insurance companies all over America, have set up so-called "preferred provider organizations." They look at the pattern of practice a given physician has over time and compare that to judgments that peers—other doctors—have rendered about how to manage specific kinds of illnesses. It's a somewhat complicated task but one that many private insurance companies are doing right now.

Senator **Cohen**. Why haven't we called upon the private sector before for guidelines as to the "conservative" practice of quality medicine. In other words, you made a statement earlier that 78 percent of the Medicare Part B premium increase is due to growth in the program, and that most of that program growth is due, in fact, to the increased utilization of physician services. Has there been any analysis done as to whether physicians are providing inappropriate or unnecessary services?

Dr. **Roper**. Yes. There is a growing body of literature that suggests that some of what is done is not necessary.

Senator **Cohen**. Well, you didn't say that in your testimony. You indicated that most of that 78 percent is due to the fact of——

Dr. **Roper**. What I said was, 78 percent of the increase is due to increased program costs, and the largest part of that is due to increased utilization, not price increases.

Senator **Cohen**. Would you furnish us with the analysis that has been done by HCFA——

Dr. **Roper**. Sure. Be glad to.

Senator **Cohen** [continuing]. Of what the causes are?

Dr. **Roper**. Yes, sir.

[Subsequent to the hearing, the following information was received for the record:]

	Dollar increase	Percentage increase	Percentage premium increase
Correction for prior projections:			
Physicians			12.1
Group practice prepayment plans			2.2
Other			—.9
Total corrections	$2.40	35	13.4
Program growth:			
Physicians			10.6
Outpatient hospital and other institutions			4.3
Group practice prepayment plans			1.3
Independent labs			.5
Total program growth	3.00	43	16.7
Contingency reserve:			
Completion of spend-down			8.0
1988 funding			.4
Total contingency	1.50	22	8.4
Total increase in premium	$6.90	100	38.5

The CHAIRMAN. Senator Shelby.

Senator SHELBY. Thank you, Mr. Chairman.

Doctor Roper, let's go back and see if I understand the figures that you were talking about earlier. Did the Part B premium increase 38.5 percent?

Dr. ROPER. It will increase that much on January 1.

Senator SHELBY. It will increase 38.5 percent over the previous amount?

Dr. ROPER. Yes, sir.

Senator SHELBY. Now, as I understand it, 13.4 percentage points of the 38.5 percent increase in the premium was what part of physicians' reimbursement?

Dr. ROPER. Do you mean, how much of that was——

Senator SHELBY. Right, how much of the 38.5 percent increase could you attribute to the increase in the physicians' expenses?

Dr. ROPER. In general—do you want precise numbers or round figures?

Senator SHELBY. Well, as tight as you can get them.

Dr. ROPER. OK. Making up for our having forecasted too low for 1987, 12.1 percent out of 13.4 percent was for physicians' services. And then our projection of growth for 1988, 10.6 percent of 16.7 percent is physicians' services. So in ball park figures, about 70 percent of the increase is due to increased physician expenditures.

Senator SHELBY. Seventy percent of the increase. Now, let's go back to the 38.5 percent. Let's break that down slowly, step by step. Would you please break that percentage down. What accounts for the increase of 38.5 percent?

Dr. ROPER. Let me try to do it as simply as I can.

Senator SHELBY. Thank you.

Dr. ROPER. What I'm talking about is what fraction of the increase each of these represent——

Senator SHELBY. Right.

Dr. **Roper** [continuing]. And 35 percent is for a correction of our prior projections having been too low; 43 percent is for our expectation of program growth through 1988; and 22 percent is for building up the contingency reserve to a prudent level.

Senator **Shelby**. Let's go back to this 35 percent. Is the 35 percent the result of a surplus that was used up?

Dr. **Roper**. Well, the surplus is the third item—the contingency reserve.

Senator **Shelby**. The 22 percent?

Dr. **Roper**. Yes, sir.

Senator **Shelby**. Because we have a lack of funds in the contingency fund, you have got to build it up. Is that correct?

Dr. **Roper**. Yes.

Senator **Shelby**. Why did you use it? Was that based on a movement of political choices, for expediency?

Dr. **Roper**. No.

Senator **Shelby**. To make you look good?

Dr. **Roper**. No. It was a desire to keep the premium as low as possible for beneficiaries——

Senator **Shelby**. Well, that's what I'm getting at. And who made those decisions? OMB? Or did you make them?

Dr. **Roper**. My predecessors did it.

Senator **Shelby**. Who was your predecessor?

Dr. **Roper**. Carolyne Davis.

Senator **Shelby**. Was this decision with the acquiescence or recommendation of OMB?

Dr. **Roper**. No. They weren't involved in that decision at all.

Senator **Shelby**. Was this done for the years 1985 and 1986, or 1986 and 1987?

Dr. **Roper**. It was for 1986 and 1987.

Senator **Shelby**. The fiscal years?

Dr. **Roper**. The calendar years. The premium is set on a calendar year basis.

Senator **Shelby**. The calendar years.

So those funds were depleted, or basically depleted?

Dr. **Roper**. We spent down a savings that had built up. The contingency was higher than it needed to be, and we—or my predecessors—chose to spend down that amount.

Senator **Shelby**. And then when it was spent down, you needed to come up with a 38.5 percent overall increase?

Dr. **Roper**. Because also during that same period, spending increased more rapidly than we had projected.

Senator **Shelby**. Doctor Roper, is there enough competition in the health care delivery system in this country?

Dr. **Roper**. No, there is not. And that's one of the things we're anxious to change.

Senator **Shelby**. Is that one of the problems—why the physicians' costs are going up and up?

Dr. **Roper**. In general, the health care system doesn't have market forces restraining costs like other parts of our economy do.

Senator **Shelby**. You also mentioned earlier in your testimony, and I've heard this from the Administration off and on, in the area of self-reliance, the movement should be toward greater reliance on private health plans in this country. But private health plans aren't going to take care of everybody in this country, are they?

Dr. ROPER. They already care for, as Senator Melcher was saying, a million of our 31 million Medicare beneficiaries, and that number is growing.

Senator SHELBY. And how many do they not take care of?

Dr. ROPER. Well, 29 million have chosen not to enroll so far.

Senator SHELBY. Well, how are people going to take care of themselves with private health initiatives if you do not have the tax incentives to do this? If we are going to make economic policy in this country——

Dr. ROPER. The private health plan under Medicare really doesn't touch on tax policy. What it does is——

Senator SHELBY. But shouldn't it touch on tax policy?

Dr. ROPER. No.

Senator SHELBY. Why?

Dr. ROPER. It simply is a different way of paying for the bills that the elderly face.

Senator SHELBY. And how does it work?

Dr. ROPER. Currently, in traditional Medicare, we pay doctors and hospitals directly. Under a private health plan, we pay instead a fixed amount per month to private plans and they, in turn, pay doctors and hospitals. So it's a different payment arrangement.

Senator SHELBY. Is it working?

Dr. ROPER. Yes, sir. Again, my hat is off to Senator Heinz and his leadership in bringing this about. It is working. We've had some bumps on the road, but with your good help we've solved them.

Senator SHELBY. Well, it would be nice if it worked everywhere. But what I'm getting at, is it going to work for everyone? It looks to me like it's going to be a mix out there. There are a lot of people who can take care of themselves, which we applaud, and I'm sure we should make policy to help them do this. But it seems to me there are a lot of people who are going to need some assistance and we should take care of these people.

Dr. ROPER. Oh, clearly we should. If I'm understanding you, though, in these private health plans—that's where the elderly get the most assistance, the most help, the least paperwork, the least hassle. But nonetheless, while we have only a portion of Medicare beneficiaries in private plans, we have an obligation to manage prudently the traditional Medicare program. And that is, as I said in my testimony, the direction we're headed.

Senator SHELBY. Doctor, your predecessors at HCFA made the decision to spend down the surplus, a decision you were not involved in——

Dr. ROPER. I probably would have made the same decision.

Senator SHELBY [continuing]. Is that good management or mismanagement?

Dr. ROPER. I think that's good management.

Senator SHELBY. It's good management?

Dr. ROPER. Yes, sir.

Senator SHELBY. And where do you determine it's good management to spend the surplus down and then raise the price of the premium by 38.5 percent?

Dr. Roper. Clearly, the wide swing in the premium is not a good thing for beneficiaries. But I make the point——

Senator Shelby. And this contributed to it, didn't it?

Dr. Roper. I make the point——

Senator Shelby. The spending-down contributed to the wide swing in the premium, did it not?

Dr. Roper. The spending allowed the elderly not to have as high a premium in 1986 and 1987——

Senator Shelby. For just a short time?

Dr. Roper [continuing]. As they otherwise would.

Senator Shelby. Wouldn't it have been better to spread the spending down of the surplus out and not have such a substantial increase in the premium for this upcoming calendar year?

Dr. Roper. I think the elderly appreciated not having to pay such a high premium in 1986 and 1987.

Senator Shelby. And do you think the elderly are going to appreciate a 38.5 percent increase?

Dr. Roper. No.

Senator Shelby. So it was basically political expedience?

Dr. Roper. Of course not.

Senator Shelby. Sure, it was.

Thank you, Mr. Chairman.

The Chairman. Senator Heinz?

Senator Heinz. Mr. Chairman, we talked about how $1.50 of the $6.90 increase is due to trust fund depletion and $2.40 of it is due to projection error. That's $3.90 of the $6.90, a majority. I did call that bad management in my opening statement. I fail to see how it's good management. I'd like now to focus on the remaining portion of the equation, namely, the $3.00 in increases that are due to physician utilization and added hospital outpatient costs.

I understand, Doctor Roper, that of that $3.00, roughly $1.95 is due to increases in physician costs, and about $0.60 of that is due to increases in hospital outpatient services. Is that correct?

Dr. Roper. That's right. Yes, sir.

Senator Domenici. Would you state that one again, please, Senator?

Senator Heinz. Yes. Of the $3.00 in increased costs due to utilization, $1.95 is due to physicians' utilization and $0.60 is due to hospital outpatient costs; paid by Part B, but paid separate from billings for doctors' services.

Now, you have proposed in the short term—and I thank you for all your kind words about HMO's and their long-term role in cost containment—but in the short term you've proposed more price controls, more intensive claims or utilization review, more bundling of services, moving to a physician DRG, and encouragements to beneficiaries to use PPO's.

Before any of us could really begin to ask any intelligent questions about these options, we need to analyze what's going on with physicians. My first question to you in terms of physician utilization is how much is due to what's called "up-coding," that is to say, billing for a more expensive diagnosis rather than a less expensive one?

Dr. Roper. I don't have precise figures, Senator.

Senator Heinz. Do you have any sense?

Dr. **Roper**. Some of it is.

Senator **Heinz**. Is there a substantial amount of it, or a minimal amount of it?

Dr. **Roper**. I would say "some" to "just a little." Aside from up-coding, the more important contributor is what we call "un-bundling"——

Senator **Heinz**. I'm getting to that.

Dr. **Roper**. All right.

Senator **Heinz**. The second question is, how much of it is due to un-bundling?

Dr. **Roper**. I think a fairly substantial part of it. For your colleagues who may not understand what un-bundling is, it occurs where we formerly paid for a collection of services with one payment, and people now choose to bill separately for the various things that go together to make up that service. The sum of the parts is always more than the original bill was.

Senator **Heinz**. And how much of this is due to beneficiaries just going to the doctor more?

Dr. **Roper**. It represents some of it, but there is still a per-beneficiary increase that is very substantial.

Senator **Heinz**. Is it relatively minor compared to un-bundling?

Dr. **Roper**. I'd just have to look at the figures carefully, but it has contributed some.

Senator **Heinz**. My information is that it's very small; not only smaller than un-bundling, but smaller than up-coding. Please check that out.

Dr. **Roper**. Okay.

Senator **Heinz**. As to hospital outpatient, we have seen increases because people who previously had procedures done in the hospital are having them done on an outpatient basis as I did on Friday. I had a knee procedure performed where I was in and out in one day; never spent the night in the hospital. As a result of this trend, services that would normally be provided by the hospital are provided in the doctor's office and they are billed for separately. Is that right?

Dr. **Roper**. That's right.

Senator **Heinz**. So that's how it comes about. And, it's due in part to DRG's, isn't it? As we squeeze down on hospital payments it becomes less profitable for hospitals to do procedures on an inpatient basis so more are done on an outpatient basis if they can be.

Dr. **Roper**. And I would just add the point to be clear, many of the things that are happening are good for patients and are to be applauded.

Senator **Heinz**. Senator Melcher made an interesting observation to you about how if we freeze physician payments, physicians will look for other ways to get the same amount of revenue. There are a lot of reasons that could happen. One would be that they've got heavy cost structures they must maintain. Another is that they have got Ferraris that they want to continue to run. A third is that there may be other factors; one that's been mentioned is malpractice. To what extent is fear of malpractice and therefore the imperative of providing a minimum set of services a factor in un-bundling?

Dr. **Roper**. I'm not sure it's a factor in un-bundling. It is surely a factor in the amount of services——

Senator **Heinz**. What I mean is, the maintenance of a certain amount of effort.

Dr. **Roper**. Certainly. It's a real factor. Secretary Bowen issued a report in August discussing in great detail the problem of malpractice and its cost. It's a major problem. Doctors across America are practicing what they call "defensive medicine" because of the fear of malpractice.

Senator **Heinz**. If that's true, how will either your approach to bundling under a DRG system or, for that matter, more intensive utilization review help? If doctors are practicing medicine because they are afraid of being put out of business by a suit, how could either of those options have a meaningful effect?

Dr. **Roper**. Well, if you assumed that all of the increase was due to a fear of malpractice, it would have no effect. I don't assume that. I assume that malpractice is a contributor and we'll have to have other solutions to that problem. Secretary Bowen recommended that States reform their tort laws, as did Indiana when he was Governor. My home State of Alabama recently did that, and I'm hopeful other States will also do that.

Senator **Heinz**. Mr. Chairman, I think I've probably taken enough time. I have some other questions I may submit for the record.[2]

The **Chairman**. Senator Domenici.

Senator **Domenici**. I would yield to Senator Chiles at the moment.

The **Chairman**. Senator Chiles.

STATEMENT BY SENATOR LAWTON CHILES

Senator **Chiles**. Doctor Roper, we were just talking about this bundling. My understanding is—and I've heard this from some of our carriers down there—where doctors before, if they were going to have to bill you for an office visit, for that office visit they did some work on you. They did a workup or they examined you or they did random tests or something. And now, they're seeing a lot of bills come in where there's "office visit" but then there's each one of the procedures. Is that what you're talking about?

Dr. **Roper**. That's un-bundling, yes, sir.

Senator **Chiles**. And you refer to that as un-bundling?

Dr. **Roper**. Right. The term arises because there used to be a bill for a "bundle" of services. And when you take apart that bundle, you bill separately for each of the items.

Senator **Chiles**. Well, when I look and see that about 60 percent of the premium increase is due to growth in physicians' expenditures, can you tell how much of that is for un-bundling and how much of that is malpractice premiums?

Dr. **Roper**. Just a guesstimate. I'd say some is due to each of those. But we don't have precise figures as to the contributor——

Senator **Chiles**. Can I just ask you what might be a very obvious question? What are you doing about it?

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[2] See appendix, p. 142.

Dr. ROPER. What we're doing about the issue of un-bundling is urging our carriers to aggregate services together and pay for the aggregate; to "re-bundle" and pay on that basis. That's time-consuming and labor-intensive but it can be done. It requires the use of computers and codes.

As far as the issue of malpractice in solving that problem, as I said, the Secretary has called on the States. Your State of Florida has struggled with this issue for several years running and I think is still struggling with it, frankly.

Senator CHILES. Well, it seems like to me, Doctor, before we can really try to do something about it, one, we've got to know how much of this 60 percent increase is coming from where, or where is it coming from? If it's un-bundling and if it's malpractice, what is the percentage that comes from that?

Dr. ROPER. Well, a large chunk of our research budget—our modest research budget, I might add, Senator—is devoted towards answering those kinds of questions. But my urging to you and your colleagues is that while we're getting those answers, we've got a major problem of 20 percent per year growth in Part B expenditures. There are some things we know we can do in the meanwhile, and we urge you to help us do them.

Senator CHILES. Well, when you are urging the carriers to un-bundle or re-bundle, are you urging them to make sure that these additional charges are not passed on to beneficiaries?

Dr. ROPER. Yes. There is a limit now placed by the Congress in last year's reconciliation bill on how much doctors can bill additionally to beneficiaries. It's well-intentioned, but let me just comment for a moment, on the so-called "maximum allowable actual charge." It has been an administrative nightmare but it seeks to do what you are asking for in your question.

Senator CHILES. How long has the un-bundling been going on?

Dr. ROPER. Oh, I think for a number of years, maybe the last decade, but it's grown more intense in the last two or three years.

Senator CHILES. In the last 2 or 3 years?

Dr. ROPER. Yes, sir.

Senator CHILES. But in spite of that we still don't have an answer as to what the extent of it is?

Dr. ROPER. No. I'm sure we have a more precise answer than I've given you this morning, and I'd be glad to supply it for the record based on our research. I just don't have it on the tip of my tongue.

Senator CHILES. Well, I would like to see that because it seems like we've got to find out.

Dr. ROPER. We'll be glad to supply that for the record.

[Subsequent to the hearing, the following information was received for the record:]

Part of the increase in physician expenditures is due to increases in the volume and intensity of services, of which unbundling of services is one component. However, at this point in time, we do not know how much of the increase is due to unbundling and how much is due to other factors, such as new technology.

To better understand how unbundling of services has contributed to increased physician expenditures, we have funded a research study with Dr. Janet Mitchell of the Center for Health Economic Research. Her analysis will look at specific components of increased physicians services in 4 States between 1983 and 1986. We hope to have findings from this study available later this year.

Senator **Chiles**. Are there other items that make up this 60 percent increase in physicians' premiums?

Dr. **Roper**. There are a variety of explanations, as I said in my testimony, including increased utilization of services in general; that is, doing more for each beneficiary, some of which is worthwhile; changes in technology; new services that formerly were not available; those kinds of things that go together to make up this 20 percent growth in program expenditures over the last 12 months.

Senator **Chiles**. I thank you, Mr. Chairman.

The **Chairman**. Thank you, Senator Chiles.

Senator Domenici.

STATEMENT BY SENATOR PETE DOMENICI

Senator **Domenici**. Thank you very much, Mr. Chairman.

If my numbers are right, the program costs in Part B have gone from 1980 costs of $11 billion to 1988, where we expect it to cost $35 billion. From 1980 to 1988, if I've done my arithmetic right, that is a 225 percent program increase.

Now, could I ask first, everyone expects a program with changing demographics—because the caseload changes—to go up. Could you tell us first how much of that increase is attributable to added caseload?

Dr. **Roper**. The growth in the elderly population we serve is about 2 percent per year. So over the period of eight years compounded, that would probably be an increase of 16 to 20 percent, something like that.

Senator **Domenici**. All right. So of the 225 percent program increase, for purposes of starting here, we might take the 25 percent and say that's attributable to increased numbers of people——

Dr. **Roper**. Population served.

Senator **Domenici**. Population served?

Dr. **Roper**. Yes, sir.

Senator **Domenici**. And that leaves 200 percent increase from 1980 to 1988—1981 to 1988.

Do you know—I don't have it; if I did, I wouldn't be asking, I would state it—do you know how that has—if you had a graph for us on the 200 percent increase, what would it look like? In 1981, 1982, 1983, would it be a shallow graph up and then go spurting up?

Dr. **Roper**. I don't have exactly the graph you're asking for but I think this one is instructive.

What this shows, Senator, is the percent change in Part B benefits per enrollee. That's what this red line is, percent increase per year. And the green line is the medical component of the consumer price index, so it's a rather generous estimation of inflation in each of those years. Remember that this is a "per enrollee" figure so the population we were talking about a minute ago is adjusted for.

So the amount of the red line above the green line in each of those years is the amount of increased services over and above an adjustment for inflation. This represents the point I was making earlier, that we as a medical community are doing more per beneficiary.

Senator **Domenici**. It looks like at the end of that graph—I can't read the years—that it spikes up and begins down. What does that mean?

Dr. **Roper**. Well, that's 1988, the downward spike. And that's our hope, that it comes down because of the series of things that we are proposing.

Senator **Domenici**. But if that doesn't happen, then obviously that trend line doesn't come down that much. It stays on that.

How much in excess of the market basket inflation, on average, is that going up there in that last two years before it comes down?

Dr. **Roper**. The top of my graph is 20 percent, so the spike is about 19 percent. And in that same year, 1987, the medical care component of the CPI was about 7 percent.

Senator **Domenici**. So it's roughly 13 percent higher than an automatic increase—it's higher than inflation because it has its special index?

Dr. **Roper**. Yes, sir.

Senator **Domenici**. Now, let me ask you, while we don't have vast numbers of Americans, comparatively speaking, covered by private carriers, we do have two systems out there that are pretty broad: private carriers, and we have the Federal Employees Health Benefit plan. Might I ask you—and if you answered this, I apologize—is the private system suffering this same problem?

Dr. **Roper**. Yes, sir. They are. Employers, unions and others that fund insurance programs are facing dramatic increases in their premiums this year, and the Federal Employees Health Benefit plan is as well for all their plans except for those generally that are HMO's or other managed care plans.

Senator **Domenici**. Do you know what the private sector is attempting to do in an effort to lower that dramatic increase that has occurred for all the reasons the Senators have indicated here, and perhaps some others? What are they doing?

Dr. **Roper**. Well, they are doing the same things we're trying to do; or more precisely, we are trying to do the same things they are trying to do—that is, fully utilize managed care plans like HMO's and competitive medical plans; establishing preferred provider arrangements that you steer patients toward; more intensive utilization review, which is on a claim-by-claim basis, evaluating the appropriateness of those kinds of claims.

If I could just make a point for a minute, Senator, that I hope I can leave with you all. Those things that I just ticked off, and especially the third one, the utilization review on a claim-by-claim basis, are the sorts of things that we very much feel need to be done. But let me make sure you are understanding that this will lead to our denying payment for claims that the doctor or other provider thinks are necessary services, and that will lead to their raising their complaints to you and your writing letters to me. And so on the one hand, the thing that you might ask of us—and I hope that you give us the money to do it—will on the other hand generate yet another hearing where I'm up here talking about all of the constituent mail that you're receiving. This is a problem that we're going to have to solve together.

Senator **Domenici**. Well, I tend to agree that to the extent that you can, for purposes of us understanding what you can do administratively and what we ought to do by way of law changes—it seems to me that to the best of your ability, and I understand it's difficult, you ought to try to break down these increases into the categories that have been discussed here. To some extent we know most of them, between malpractice, un-bundling, movement away from hospitals to outpatient treatment, which is becoming a national policy. It puts more of a burden on this. We aren't seeing the hospital costs go down very much, but that ought to show up some time or another, I guess.

Dr. ROPER. Surely, I'll supply those for the record, sir.[3]

The movement out of hospitals is one explanation for this phenomenon of increased Part B growth, but it by no means is the full explanation. I think what we are seeing is a more than decade-long phenomenon that is growing more rapidly; that is, doctors are doing more for patients. And in my view the only way to get a handle on that is to start questioning those decisions. As a physician, I would rather not do that. I'd rather delegate that to private plans than have the Government do it directly.

Senator DOMENICI. Well, let me just ask two last questions.

Could you give the committee—perhaps the Secretary has already done it—a summary of the malpractice, so-called "malpractice reform status" in the United States and how effective it has been? I understand in some States the legislatures have tried it, and even there have been challenged judicially. Could we have a summary of where that stands?

Dr. ROPER. I'd be glad to do that. His report of August is primarily current, but we'll update that where needed.

[Subsequent to the hearing, the following information was received for the record:]

"MALPRACTICE REFORM STATUS"

In response to problems of malpractice insurance availability and affordability of the 1970's, virtually every State enacted some modification of its tort system. Another round of tort reform began in the 1980's. Description of popular tort reform provisions are contained in the *Report of the Task Force on Medical Liability and Malpractice* issued last August, a copy of which is attached. The report also describes in general terms the degree to which States have adopted individual reforms, some of the judicial challenges they have faced, and the results of research on their efficacy.

As part of our implementation of the report's recommendation, the Department, in conjunction with the Department of Justice, drafted model State tort reform legislation. Principal components of our model include:

Limits on noneconomic damage awards: The model law would cap noneconomic damage awards at $200,000, the level advocated by the Department of Justice.

Joint and several liability: The model legislation would eliminate the doctrine of joint and several liability except where it can be proven that the defendants actually acted in concert to cause the same injury.

Sliding scale for attorney fees: The legislation sets out a sliding scale limiting the percentage of award which can be used for attorneys' fees: 25 percent of the first $100,000, plus 20 percent of the next $100,000, plus 15 percent of the next $100,000, plus 10 percent of any amount in excess of $300,000.

Periodic payments: Damages for future economic loss which exceed $100,000 would be paid in periodic installments instead of a lump sum under the model law.

Statute of limitations: The model legislation proposes a statute of limitation requiring that legal action begin within two years after a relationship between a medical event and an injury was discovered or reasonably should have been discovered.

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[3] See information provided on page 30.

Required arbitration: The legislation authorizes the use of mandatory nonbinding arbitration. Litigants would be required to arbitrate a dispute before a single arbitrator. Traditional tort remedies could be pursued if either or both parties were not satisfied with the arbitrator's decision.

We have distributed the model to the Governors and legislative leaders of the States for their consideration during 1988 legislative sessions. Many States are considering tort reform this year and we have taken an active role in assisting several States in their deliberations.

Tort reform, however, is just one component of a balanced program addressing medical liability. The Department's August report also contained recommendations addressing health care, alternatives to litigation and insurance. Through a range of Departmental activities we hope, among other things, to encourage public and professional education, quality assurance and risk management activities, and better monitoring of Federally employed physicians. We also hope to encourage the strengthening of State licensing boards and better communication between the boards and Peer Review Organizations.

The National Center for Health Services Research and the Assistant Secretary for Planning and Evaluation are both sponsoring research on the effectiveness of various malpractice reforms. The Department is also sponsoring a research conference on medical liability and related health care quality issues in April.

Senator DOMENICI. My last question is, Congress and the Administration have tried to help solve this problem. Principally we've done that by holding down annual price increases on physicians to less than inflation. That's been our principal tool around here, either in one, two or three reconciliation bills—I can't remember, but that's what we've done. We've said, "We're holding down the increase in physicians' automatic increases," and we have touted that as having no impact on the beneficiary because it was all going to be against the provider.

If I read you right, that has not quite worked. Is that right?

Dr. ROPER. Well, price controls have an effect in the short term. But as price controls do in any other part of the economy, they begin to unravel as people under those controls change their behavior. So I don't hold out price controls as a long-term solution.

Senator DOMENICI. I thank you.

Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Domenici.

Doctor Roper, we've gotten into quite a discussion here about malpractice. Have you got some indication that malpractice suits are high among older Americans that are on Medicare?

Dr. ROPER. From the evidence I've seen, they are not higher than the general population.

The CHAIRMAN. Are they the same, or lower?

Dr. ROPER. The last study I saw, they were somewhat lower than the general population.

The CHAIRMAN. They were somewhat lower among older Americans, and therefore lower among Medicare recipients?

Dr. ROPER. Yes, sir.

The CHAIRMAN. Well, would there be any difference between Medicare patients who are on Part A and in a hospital, and Medicare patients who are on Part B and going to the doctor's office for their examinations?

Dr. ROPER. You mean the likelihood of a lawsuit arising under Part A or Part B?

The CHAIRMAN. Yes, any evidence that malpractice suits are greater among Part B.

Dr. ROPER. I've never seen that studied, sir.

The CHAIRMAN. Why are we talking so much then about malpractice being a part of the cost of this? I understand physicians when they tell me that their malpractice insurance fees are extremely high, and that they'd like to see something done about it so that it doesn't have to add to their overhead. But we're talking about older Americans here under Part B of Medicare. I'm wondering whether it's even very relevant to indicate that malpractice insurance cost increases are part of the reasons that this Part B fee is going up for Medicare recipients. I just wonder if we aren't sort of chasing after a rabbit that we're not going to catch.

Dr. ROPER. I think it would explain some of the increase but I wouldn't say it's a major contributor.

The CHAIRMAN. I have grave concerns about what's happening in malpractice fee charges for physicians because I think it sometimes almost forces some physicians out of practice, particularly in obstetrics, surgery, a number of different specialties. But I don't really believe that's going to explain very much of why this cost is going up. I know that physicians can't break down their charges and say, well, since it doesn't cost so much malpractice, on my fees for older Americans I'll charge them less. They generally don't do that. But nevertheless, I think if we continually talk about how malpractice contributes to this cost we may be getting ourselves just mixed up in a lot of gobbledegook and not get to the real root of why these fees are going up for Part B.

You earlier stated that competition is lacking. Could you expand on that?

Dr. ROPER. I think there are a variety of ways of making that point. Generally put, health care has not had the sort of competition that is in place in other parts of our economy. Evidence of that is that we have an increasing population of medical practitioners and a large volume of unused hospital beds, but we are only beginning to see falling prices as a result. So the laws of supply and demand haven't worked to the same extent in the health care community as they have elsewhere in our economy.

The CHAIRMAN. In other words, there are more physicians out there practicing but you don't believe there has been enough time to where that brings down the situation, the competition? Is that what you're telling me?

Dr. ROPER. We're just beginning to see real incomes falling among physicians despite the fact that the number of physicians has grown dramatically in the last couple of decades.

The CHAIRMAN. Well, Doctor Roper, you've been very forthright in your testimony and in your response to questions today and I very much thank you for that. But I'll end where I started, I think we have a joint responsibility, and maybe the major responsibility is in Congress itself, to do something to hold down the rapid increase in Part B costs for Medicare beneficiaries. So I think you ought to select one or two of those options that are available and start making some solid recommendations.

Dr. ROPER. We have done that, sir.

The CHAIRMAN. You recommend capitation. And while I can't disagree with you—capitation is fine—we know that it's going to restrict itself, probably, to urban areas and probably won't reach out into the larger part of America. And when I say "urban," I mean real urban. I don't even think we're talking about suburbia in lots of cases with capitation.

But at any rate, that's only a partial solution. I think that grouping these fees for services under one—what you call "bundling"—I think that must have some real merit, too.

Dr. ROPER. Surely.

The CHAIRMAN. And if you can be more specific on how we would utilize those, I know I would welcome—I think the whole committee and the whole Congress would——

Dr. ROPER. I'd be glad to submit that for the record.[4]

The point I was going to make, Mr. Chairman, is the range of things that we have recommended for this year's legislative package. For example, we've proposed a further cut in the amount we pay per cataract surgery for the Medicare population. We proposed a reduction last year, and the Congress chose to go along with a lesser reduction. This year we are proposing a further reduction.

The CHAIRMAN. For cataracts?

Dr. ROPER. Yes, sir.

We seek to reduce payments for other overpriced procedures, and I believe that the Ways and Means Committee in the House and the Finance Committee in the Senate will give us that authority.

And finally, we have proposed limiting the amount of increase on a per-fee basis for all except primary care services, and I believe the relevant committees will go along with that, as well.

The CHAIRMAN. Well, I'm under the impression that we adopted your recommendations on cataract surgery. Is that correct?

Dr. ROPER. Yes, sir.

The CHAIRMAN. But you have other recommendations that you don't think we properly responded to?

Dr. ROPER. Thus far in the reconciliation process I'm pleased with the action that the House and the Senate have taken.

The CHAIRMAN. So you think there's some progress——

Dr. ROPER. Yes, sir.

The CHAIRMAN [continuing]. In following up on your recommendations. But isn't bundling a much bigger problem than just a few procedures?

Dr. ROPER. Surely. It's a widespread problem.

The CHAIRMAN. All right. Then we would like to have more recommendations.

Dr. ROPER. Okay.

The CHAIRMAN. Thank you.

Senator HEINZ. Mr. Chairman, I have——

The CHAIRMAN. Yes, Senator Heinz.

Senator HEINZ. Mr. Chairman, following up from where Senator Domenici left off, you indicated in the chart that per-beneficiary costs are increasing at a much faster rate, maybe two or three times that of the medical CPI——

Dr. ROPER. Yes.

Senator HEINZ [continuing]. I would assume that you have done a variety of analyses to find out what the correlants of that increase are, whether they correlate to the age of the patient, to the introduction of new procedures, or to types of illnesses. I don't want you to give all of that now, but I would appreciate—and maybe other members of the committee would appreciate—your sharing with the committee your analysis of why the per-beneficiary or per-enrollee cost has been going up, or at least those things that it correlates to——

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[4] See information provided on page 36.

Dr. ROPER. Surely.

Senator HEINZ [continuing]. Which are not the same as causes; they are simply correlants.

My next question to you is this. Earlier you proposed a number of ways to limit what you might call "inappropriate" or "unnecessary" physician services. How will we track and ensure that patients, within our definition of what is appropriate, won't be out of the test or the visit or the time with their doctor that they need? More specifically, what role will either PRO's or beneficiaries have in giving us feedback on either of your principal approaches to controlling costs by either evaluating or ensuring the quality of care as we cut back on costs of care.

Dr. ROPER. You have asked a very important question. It is: Once we have done all these things, how can we make sure that we've improved the quality of care in the program and not let it slide?

What I would say in response is that we need to press ahead quickly, as we are now, with the help of researchers and the provider community and come up with better measures of quality in the system. We've got some crude measures based largely on mortality rates, but I'm hopeful that within a year or two we'll have much better measures of quality. It will be important that we monitor individual doctors and individual hospitals to see what the impact of their care is, to make sure what they do really has a good outcome for the person treated.

To answer your specific questions, the role for PRO's is expanding under the new authorities that you gave us last year in reconciliation. More and more we are reviewing outpatient care under the PRO program, and I think that's important.

The role for beneficiaries in general is one of raising concerns and having us continue to be vigilant in overseeing the program, and I welcome those kinds of messages from AARP and others.

Senator HEINZ. Mr. Chairman, thank you.

The CHAIRMAN. Thank you very much, Doctor Roper.

Our next witness will be Robert Maxwell, Vice President, American Association of Retired Persons.

Mr. Maxwell, we are glad to have you here today and we are interested in what AARP has to say on this problem of the gigantic increase in Part B Medicare costs.

STATEMENT OF ROBERT MAXWELL, VICE PRESIDENT, AMERICAN ASSOCIATION OF RETIRED PERSONS, ACCOMPANIED BY STEPHANIE KENNAN, LEGISLATIVE REPRESENTATIVE, AARP

Mr. MAXWELL. Thank you, Mr. Chairman. I am Vice President of AARP and as of about a month ago, I feel that I am here representing about 27 million members, many of whom are under Medicare.

I brought Stephanie Kennan with me, who is on our national staff and who works on Federal affairs, a portion of our work.

Frankly, we think that the 38.5 percent increase in Part B is both frustrating and alarming to our beneficiaries because it is a sign that the health care system is simply out of control.

I am submitting for the record a fact sheet showing the beneficiary liability for physician services as part of my written testimony. Nearly all of the beneficiaries of Medicare paid the Part B premium. Since 1977, the premium has increased almost 150 percent. Not only are Medicare premiums increasing but premiums for other health care insurances are also increasing at a rapid rate. For example, Federal employees' health plans will be increasing approximately 30 percent; the HMO's, however, are increasing much more slowly.

We think that the cause of the latest crisis cannot be blamed on beneficiary behavior. Statistics show that over the past decade the number of physician office visits per enrollee have remained relatively stable. What has changed is the number and the price of services that are being billed per visit. These are two factors over which the beneficiary has no control; the doctor sets them.

What I want to stress on behalf of our membership is that beneficiaries are willing to pay their fair share of the costs of Medicare, but we simply can't accept an open-ended liability. If the projected increase does occur, the number of beneficiaries who will in effect see no cost of living adjustment will go from 600,000 this year to 742,000 next year. These beneficiaries' Social Security checks will not decrease because the current law holds them harmless, but the growing number of beneficiaries in this category could jump dramatically if the same conditions exist for 1988 and again in 1989.

In addition, approximately 750,000 beneficiaries will have their COLAs reduced to $1 or less because of this large premium increase.

Now, what can be done to protect both beneficiaries and the Treasury from runaway costs and steep increases in Part B premiums? Hopefully, in the long run we'll be able to bring increases in Part B in line with the increases in general inflation.

This current controversy makes physician payment reform even more urgent. Payment reform must create fair and objective payments, but should also protect beneficiaries from large, unpredictable out-of-pocket costs without creating barriers to care.

We continue to support a resource-based relative value scale to achieve this goal. I would also like to add that AARP supports the inclusion of mandatory assignment when and if fair payments are created. But this alone will not address the issue of intensity of services. Utilization controls based on patient outcomes must be developed and implemented. We have no scientific data that shows that an increase in intensity of services has resulted in appreciably greater health status of beneficiaries.

Congress and beneficiaries must question what value we are receiving for our money.

While considering payment reform, we urge Congress to keep in mind the size of the cost of living adjustment beneficiaries receive and devise, perhaps, a rule of thumb by which the premium will be permitted to rise. While the premium should not necessarily be pegged to the cost of living adjustment, the premium increase should not be far in excess of this amount, as we have in the current situation.

In the interim, we urge Congress to take the following steps.

First, determine what the appropriate level of the reserve should be, and then determine the rate at which the reserve should be built. Program managers have a responsibility to determine this accurately. When decisions are made causing the reserve level to drop dangerously low, the reserve should be replaced, but not so quickly as to impose a hardship on beneficiaries. Beneficiaries are appreciative that there was no premium increase in 1986, but now we're paying catch-up for that decision made two years ago. We're trying to catch up in one huge leap.

Second, we urge Congress to pass pending budget reconciliation legislation that achieves short-term savings in Medicare while protecting beneficiaries from further cost shifting.

Third, we encourage Congress to strengthen those ways in which beneficiaries can limit their liability for physician services until these reforms can be achieved. The participating physician program is one way in which beneficiaries can limit their out-of-pocket costs, but there is still great variation among specialty and geographic locations.

AARP continues to support giving participating physicians a larger update next year.

Last, we urge this Congress to focus on physician payment reform as soon as possible, and we look forward to working with you on this challenging issue. We thank you, Mr. Chairman, for allowing us to make our points today.

[The prepared statement of Mr. Maxwell follows:]

AARP

STATEMENT

of the

AMERICAN ASSOCIATION OF RETIRED PERSONS

on

INCREASES IN MEDICARE PART B PREMIUMS

Presented by:
Robert Maxwell, Vice President
before the

SENATE SPECIAL COMMITTEE ON AGING

Washington, D.C.
November 2, 1987

Mr. Chairman, my name is Bob Maxwell. I am Vice President of the American Retired Persons (AARP) which represents over 27 million members. I am pleased to testify before you on the impact on beneficiaries of the Medicare Part B premium increase.

The projected 38.5 % increase in the Part B premium is alarming and frustrating to beneficiaries because it is a sympton of an out of control health care delivery system. I would like to submit for the record a fact sheet on "Medicare Beneficiary Liability for Physician Services" prepared by AARP's Public Policy Institute which demonstrates the effect of our current payment policies on beneficiaries.

Beneficiary Liability for Part B

Nearly all beneficiaries pay the Part B premium which has been rising steadily. The 1987 annual premium was an increase of 15% over 1986. Part B outlays jumped 20% in the past year. If the projected 38.5 premium increase does occur then the cumulative increases in the premium will equal 150% since 1977. In contrast next year's Social Security cost-of-living-adjustment (COLA) will be only 4.2%.

In addition to the premium, beneficiaries have other liabilities under to Part B. The Part B deductible of $75 actually represents about $100 in out-of-pocket costs because only Medicare's allowed charges count toward the deductible and the average reduction on Part B claims is about 26.5 percent. Beneficiary liability for the 20% Part B co-insurance more than doubled between 1980 and 1984 and rose from 20% of overall liability to 32% between 1975 and 1985. Despite increased acceptance of assignment, charges associated with non-assigned claims totaled $2.6 billion in 1985 - an increase of 100% since 1980. In addition there is enormous variation in assignment rates by state and physician speciality - factors over which patients have no control.

Health Care Costs

Skyrocketing costs afflict all aspects of fee-for service medicine. Unprecedented increases in program costs are not limited to Medicare; federal employees' health insurance premiums are also going up about 30%. HMO's with medicare risk contracts whose increases are based on fee-for-service costs in their specific areas are receiving an average increase in payment of 13.5%. In contrast, HMO premiums not based on the fee-for-service sector are expected to rise much more slowly next year.

The cause of this latest crisis in Medicare cannot be attributed to beneficiary behavior. Government statistics show that the average annual number of physician office visits per enrollee has been virtually the same for the past decade. This figure is approximately 5 office visits per enrollee. What has changed is the price and intensity of services provided during these visits. These two factors - the intensity and price of services - jointly account for most of the historic increases in Part B outlays. Beneficiaries do not control either of these factors.

Let me stress that beneficiaries are willing to pay their fair share of the cost of Medicare, but cannot accept an open-ended liability over which they have no control.

If the projected increase of over 38% in the premium occurs, approximately 742,000 beneficiaries receiving Social Security checks will fall under the current "hold harmless" provision. This provision prevents the Social Security check from dropping in instances where the cost-of-living adjustment is less than the premium increase. These beneficiaries, in effect will not see a COLA. In 1986 approximately 600,000 beneficiaries were held harmless. If the Part B premium were to rise the same amount again in 1989, and beneficiaries received the same 4.2% COLA, the number of beneficiaries held harmless would be over 3 million.(see charts 1 & 2).[1]

In 1988 an additional 750,000 beneficiaries will have their COLAs reduced to $1 or less in effect because the premium increase will take the majority of their COLA.

Program Management

Run away costs and cost-shifting are signs of a poorly managed program. An issue which must be addressed is the role of the SMI reserve and the way in which the reserve interacts with the calculation of the Part B premium. In 1986 there was no increase in the premium and now we are told that part of the projected increase for 1988 is partially due to a miscalculation and the need to rebuild the reserves.

Medicare's program managers have a responsibility to determine the proper level of the reserve fund to cover expected expenses. The amount of reserves has fluctuated historically. While management has an obligation to restore the reserve to an acceptable level, this should be done gradually so a hardship is not imposed on beneficiaries. For example, the 1983 Social Security Amendments permitted the OASDI trust fund reserve to be built up at a gradual rate. This approach should be adopted in order to build the reserve without burdening beneficiaries for management mistakes.

In addition, our current health care system fails to control utilization effectively. Physicians in the fee-for-service sector have a blank check. The physician determines the clinical management of the patient's case - what tests and procedures are to be done. We need to determine how much the unbundling of services - charging for each step in a service rather than the whole package has also contributed to the increase in volume and therefore program costs. In neither instance does the beneficiary have control over those decisions. Beneficiaries and Congress need to ask what value we are receiving for our money.

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[1] Some, of these small check beneficiaries may be Medicaid dual-eligibles, for whom the premium is paid, though the precise number is is not apparent to us.

Physician Payment Reform

Congress identified the need for physician payment reform under Medicare when it created the Physician Payment Review Commission to create a blueprint for reform. This current crisis makes that reform all the more necessary and urgent.

The Association firmly believes that Part B of Medicare must be reformed as quickly as possible to achieve the following long-term goals:

1. Protect beneficiaries from large and unpredictable out-of pocket costs;

2. Control program outlays so increases are more in line with general inflation;

3. Reform physician payment so that fees are based on a resource based relative value scale with increased payments for undervalued services such as nursing home visits and primary care of those with multiple chronic conditions;

4. Deliver medically necessary and appropriate care by developing utilization controls based on quality of patient outcomes.

Our recommendations for payment reform are based on several important principles. First, reduced Medicare payments for physician services, such as those adopted under the rubric of "inherent reasonableness", should not result in cost-shifting to beneficiaries. Unless these reductions are accompanied by statutory limits on balance billing, this inevitably will occur. We favor the approach to limits on payments like those Congress adopted for cataract surgery in the FY 1987 Budget Reconciliation

Act. Beneficiaries already directly pay about $3 billion for physician fees in excess of Medicare's allowed amount. Beneficiary liability will surely skyrocket if Congress and the Physician Payment Review Commission pursue program savings without including protections from balance billing on unassigned claims.

Second, revision of Medicare's physician payment system should not just satisfy physician perceptions of fairness and rationality. A truly meaningful payment reform must also limit beneficiary liability to predictable and manageable amounts. In our view, there is no reason why physicians ought not to accept Medicare's allowed fee as payment in full if that amount is based on a system that is objectively fair and reasonable. That is, mandatory assignment should be a component of a reformed Part B payment method.

The Association approaches the issue of mandatory assignment absent fee reform with caution because of the risk of creating access problems for beneficiaries residing in areas with low assignment rates and low physician/population ratios.

Third, efforts to control Part B expenditures must be designed to ensure that Medicare payments are not set so low that access to care is jeopardized.

Fourth, since a large component of increased outlays for physician services is an increased number and intensity of services per physician contact, utilization review must accompany cost control lest physicians off-set lower fees by higher volume of services. There is little evidence that increased intensity of physician services has appreciably improved the health status of beneficiaires.

Organized medicine for many years has stated that it can police itself. We suggest that beneficiaries, physicians and Congress cooperate to address these needs - protection from an increasing beneficiary liability, fair fees and reduced program costs. An individual physician cannot change the net negative effects of the current program. Organized medicine must begin to play a more cooperative role in developing utilization controls for the delivery of services which will increase the quality of care as well as holding the line on program costs.

Interim Measures

As physicians, beneficiaries and Congress begin to address the issues of physician payment reform, AARP recognizes that much of what is needed to improve the system cannot be done instantly. Interim steps are needed.

We encourage Congress to consider the following:

1. Determine an adequate and desirable SMI reserve level and mandate a gradual rate of increase to build the reserve that would not impose an undue burden on beneficiaries.

2. Passage of pending budget reconciliation legislation to achieve short-term savings in Part B. This should have some impact on the premium since it will reduce program outlays

3. Strengthening of the participating physician program. While this does not address the increase directly, it would provide beneficiaries an opportunity to control the out-of-pocket costs they incur for physician service. Efforts should be targeted at States and specialties with low assignment rates. We oppose penalties on beneficiaries for failure to use participating physicians. Beneficiaries have no power over the physician's decision whether or not to participate and changing physicians solely on the basis of price could seriously disrupt the continuity of our care and be a hardship on patients.

Finally while the idea of directories of participating physicians is laudable, they must be monitored for accuracy — otherwise they will be of little use in selecting a physician on the basis of his or her assignment practices. I have found my directory to be inaccurate and think my experience may not be unusual.

Conclusion

Congress cannot permit Medicare program costs to continue unchecked. We hope that this latest controversy will force action on physician payment reform earlier than otherwise might have occured.

As Congress looks at overall reform of the Part B program, we believe that you must also take into account how fast premiums will rise. Congress must weave into its reforms a rule of thumb of how much the Part B premium will be permitted to increase even after reform takes place. In developing this guideline, Congress should also take into account the amount of the cost-of-living-adjustment beneficiaries receive.

Premium increases should not necessarily be pegged to the COLA, but they should not rise at a rate far in excess of the COLA as will be the case this year.

The issue of volume and the unbundling of services must become the top priority of Congress in addressing this crisis on a long term basis. A resource based relative value scale alone will not address the volume issue.

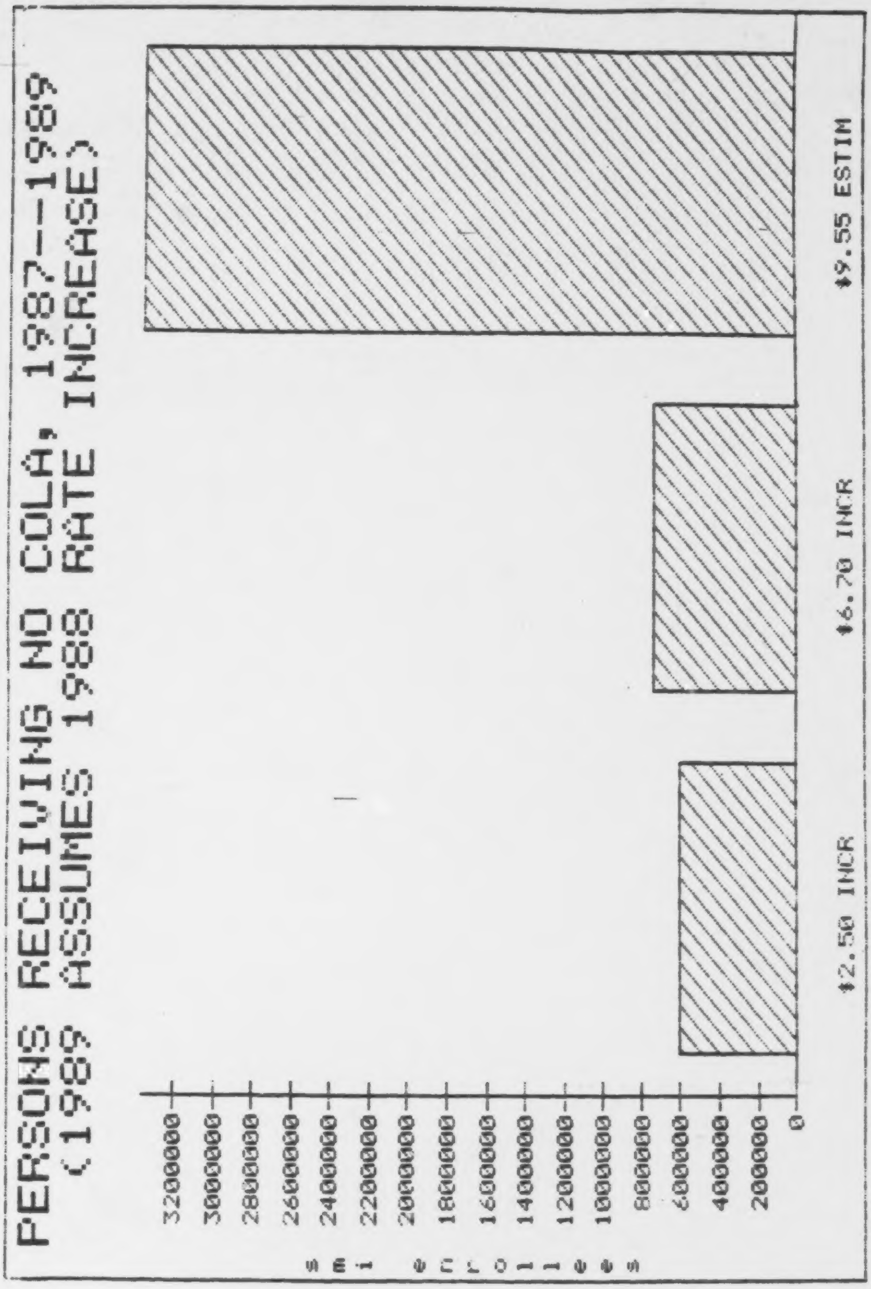
The Association looks forward to working with Congress in determining how to deliver cost-effective quality care to Medicare beneficiaries. This challenge will not only affect current beneficiaries, but many generations to come.

COST OF INCREASED MEDICARE PART B PREMIUM, 1988
NUMBER OF BENEFICIARIES NOT RECEIVING COLA

SMI ENROLLEES	AVERAGE MONTHLY SOC SEC	4.2% COLA	PART B PREMIUM INCREASE	NET CHANGE	TOTAL COST
2,900	$5.00	$0.21	$6.90	-$6.69	$19,401.00
3,800	$15.00	$0.63	$6.90	-$6.27	$23,826.00
4,300	$25.00	$1.05	$6.90	-$5.85	$25,155.00
7,500	$35.00	$1.47	$6.90	-$5.43	$40,725.00
9,700	$45.00	$1.89	$6.90	-$5.01	$48,597.00
15,300	$55.00	$2.31	$6.90	-$4.59	$70,227.00
15,700	$65.00	$2.73	$6.90	-$4.17	$65,469.00
44,300	$75.00	$3.15	$6.90	-$3.75	$166,125.00
43,900	$86.00	$3.61	$6.90	-$3.29	$144,343.20
45,900	$96.00	$4.03	$6.90	-$2.87	$131,641.20
59,400	$106.00	$4.45	$6.90	-$2.45	$145,411.20
54,000	$116.00	$4.87	$6.90	-$2.03	$109,512.00
85,800	$126.00	$5.29	$6.90	-$1.61	$137,966.40
117,200	$136.00	$5.71	$6.90	-$1.19	$139,233.60
116,400	$146.00	$6.13	$6.90	-$0.77	$89,395.20
116,200	$157.00	$6.59	$6.90	-$0.31	$35,557.20
282,700	$167.00	$7.01	$6.90	$0.11	$0.00
234,900	$177.00	$7.43	$6.90	$0.53	$0.00
361.200	$187.00	$7.85	$6.90	$0.95	$0.00
324,000	$197.00	$8.27	$6.90	$1.37	$0.00
717,500	$207.00	$8.69	$6.90	$1.79	$0.00
315,000	$217.00	$9.11	$6.90	$2.21	$0.00
376,800	$227.00	$9.53	$6.90	$2.63	$0.00
419,300	$238.00	$10.00	$6.90	$3.10	$0.00
459,700	$248.00	$10.42	$6.90	$3.52	$0.00
....	....				

PERSONS W/ NO COLA MONTHLY COST $6.90 $1,392,585.00

$6.90 PART B 742,300 ANNUAL COST $6.90 $16,711,020.00


PERSONS RECEIVING NO COLA, 1987--1989
(1989 ASSUMES 1988 RATE INCREASE)
3200000
3000000
2800000
2600000
2400000
2200000
2000000
1800000
1600000
1400000
1200000
1000000
800000
600000
400000
200000
0
$2.50 INCR
$6.70 INCR
$9.55 ESTIM

AARP PUBLIC POLICY INSTITUTE ISSUE BRIEF

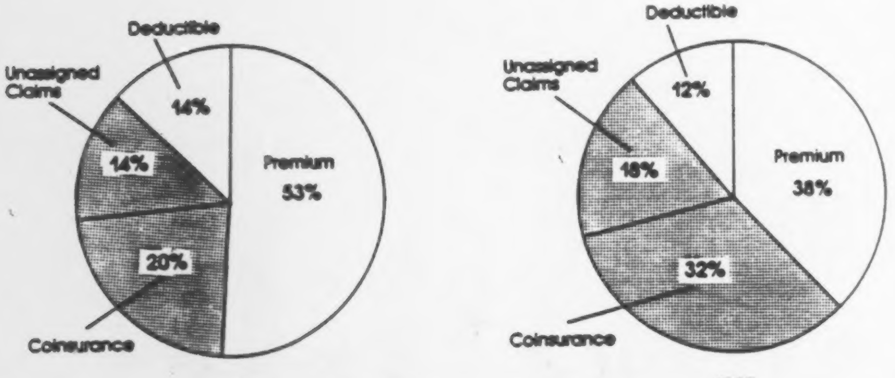
FACT SHEET

MEDICARE BENEFICIARY LIABILITY FOR PHYSICIAN SERVICES

I. Liability for Medicare-Covered Physician Services

Medicare beneficiary liability for physician services consists of four components: Part B premium payments, an annual deductible, coinsurance, and charge reductions on unassigned claims. The relative contribution of these four categories to total beneficiary liability for physician services has shifted over time. In 1975, premium and deductible expenditures represented 67% of total beneficiary liability for physician services. By 1985, coinsurance and charge reductions, two categories of expenditure which are essentially unpredictable, played as significant a role in total physician service liability as premiums and deductibles.

BENEFICIARY LIABILITY FOR MEDICARE-COVERED PHYSICIAN SERVICES

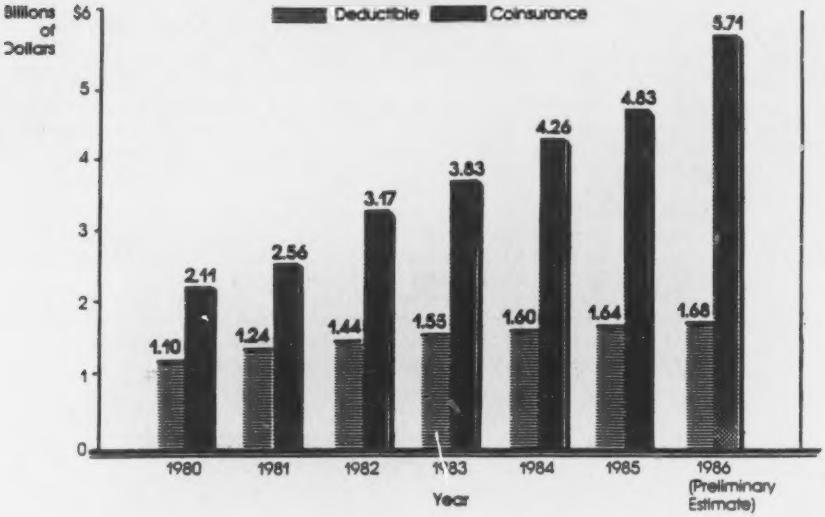


Public Policy Institute • Division of Legislation, Research & Public Policy
American Association of Retired Persons • 1909 K Street, N.W., Washington, DC 20049 • (202) 872-4700

Source: HCFA

Beneficiary payments for the four categories of liability for Medicare-covered physician services have risen steadily. The following charts track increases in liability components since 1980.

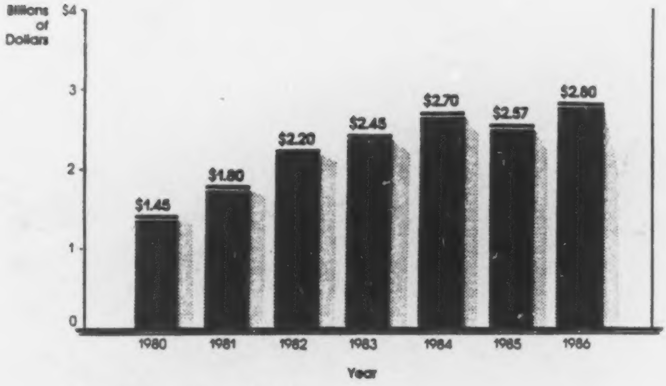
MEDICARE PART B DEDUCTIBLE AND COINSURANCE LIABILITY FOR THE AGED*



*Includes Physicians and Other Medical Suppliers

Source: HCFA, Office of the Actuary, January 1987

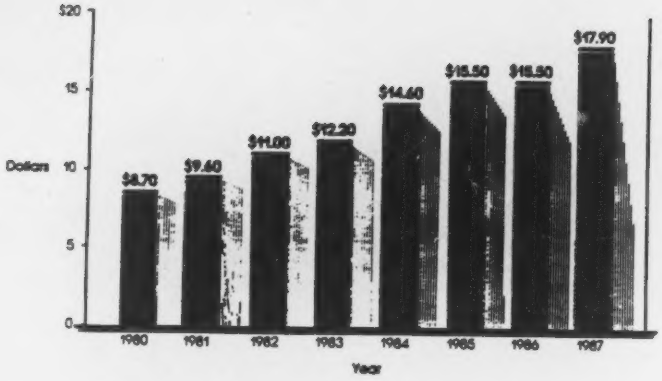
CHARGE REDUCTIONS ON UNASSIGNED MEDICARE PART B CLAIMS*



*Includes Physicians and Other Medical Suppliers

Source: HCFA

MEDICARE PART B MONTHLY PREMIUM

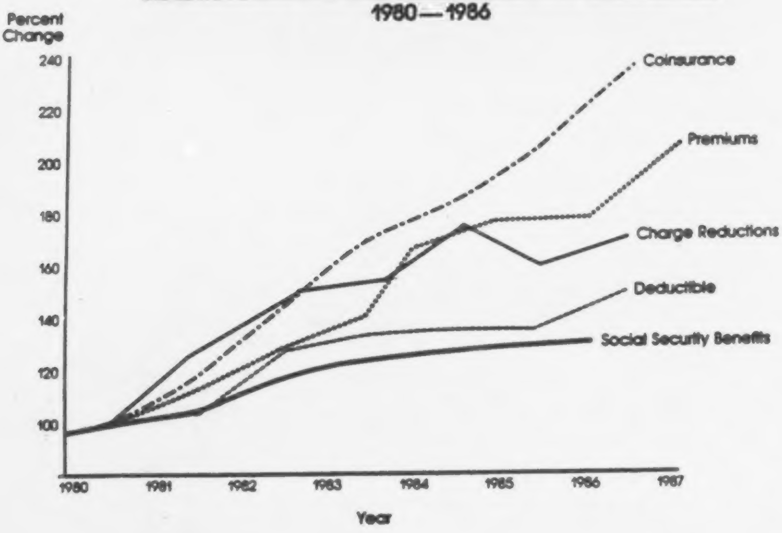


Source: Trustees' Report, April 1986.

While there have been significant increases in all four categories of liability stemming from the use of physician services, there has also been considerable variability in the rate of increase among the four liability components.

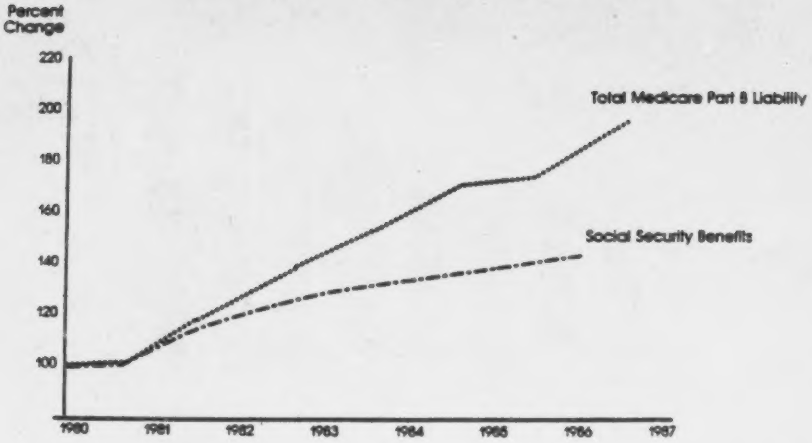
Moreover, increases in Social Security benefits have been unable to keep pace with increases in physician-related beneficiary liability.

COMPARISON OF CUMULATIVE CHANGE IN SOCIAL SECURITY BENEFITS AND COMPONENTS OF MEDICARE PART B LIABILITY 1980—1986



Source: HCFA; Social Security Bulletin

COMPARISON OF CUMULATIVE CHANGE IN SOCIAL SECURITY BENEFITS AND TOTAL MEDICARE PART B LIABILITY 1980—1986



Source: HCFA ; *Social Security Bulletin*

II. Who is Affected?

o Part B Premium:	97% of elderly Medicare beneficiaries purchase Medicare Part B coverage.
o Deductible:	80% of elderly Medicare beneficiaries make payments toward the deductible for physician services.
o Coinsurance:	60% of elderly Medicare beneficiaries use Medicare-reimbursed services, thereby triggering coinsurance liability.
o Charge Reductions on Unassigned Claims:	80% of elderly Medicare beneficiaries with reimbursement for physician services had some liability from unassigned claims in 1982, up from 70% in 1975. There is considerable disparity across states in the percent of elderly beneficiaries with unassigned claims, from a low of 51% in Rhode Island to a high of 95% in Oregon. (HCFA is currently unable to provide these figures beyond 1982).

Note: While 80% of elderly Medicare beneficiaries incur liability from the use of physician services, only about 23% incur liability from the use of hospital services.

III. The Impact of Assignment

- o Given the magnitude and unpredictability of beneficiary liability stemming from unassigned claims, the physician's decision to accept or reject Medicare assignment can be critical to the patient.

- Under Medicare's "participating physician" arrangement, 28.4% of physicians treating Medicare patients in 1986 agreed to accept assignment for all Medicare claims, a drop of two percentage points over 1985. There is, moreover, great disparity from state to state in the percentage of participating physicians from a low of 8% in South Dakota to a high of 54% in Alabama (1986).

  A similar disparity in participation rates exists across specialties, with a low of 22% for anesthesiologists to a high of 46% for nephrologists.

- The 1985 assignment rate was 68.5%, up dramatically from the 1984 rate of 59%. This improvement in assignment rates is attributable in large part to the implementation of the participating physician program in 1984. Moreover, gains seen in assignment rates in 1985 seem to have held in 1986, when assigned claims made up 68% of the total.

  (It should be noted that the current assignment rate for non-participating physicians is about 44%).

Medicare Part B Assignment Rates
1968-86

Year	Percent of Claims Assigned
1968	59.0
1970	60.8
1972	54.9
1974	51.9
1976	50.5
1978	50.6
1980	51.5
1982	53.0
1984	59.0
1985	68.5
1986	68.0

Source: HCFA

- Still, there remains significant variability in assignment rates across states. In 1986, 92% of claims submitted in Massachusetts were assigned, while only 35% were assigned in South Dakota. Assignment rates for specialties vary, as well, but HCFA has not updated these since 1982.

- Most physician charges submitted to Medicare are reduced prior to reimbursement. Between 1971 and 1985, the percent reduction on physician charges increased from 11.4% to 26.9%. The beneficiary bears the full financial burden of such reductions on all unassigned claims.

- The recent increase in unassigned claim liability during a period characterized by high assignment rates suggests possible increases in volume, the use of more expensive physician services, the influence of the two percentage-point decline in the physician "participation" rate, or a combination of these three.

IV. The Role of Medigap

- Most Medicare supplemental (Medigap) policies marketed since the enactment of the Baucus Amendment in 1980 are required to cover Medicare Part B coinsurance subject to a maximum plan deductible of $200 per year; they must also carry a maximum Part B benefit of not less than $5000. Relatively few Medigap plans cover even a portion of unassigned claim liability, and the cost of such coverage is usually prohibitive.

- About 70% of elderly Medicare beneficiaries purchase Medigap insurance plans. About 90% of these individuals are covered for inpatient physician care, and about 62% are covered for physician office visits.

- The cost of Medigap insurance ranges from about $200 to $1,200 per year, depending on the breadth and depth of coverage.

V. Elderly Out-of-Pocket Expenditures for Physician Services

Elderly out-of-pocket expenditures for physician services (including payments for non-Medicare covered services) are large and rising. Between 1977 and 1984, such expenditures increased by 195%.

	1977	1984	Percent Increase
	Billions		
Out-of-Pocket:	$2.2	$6.5	195%
Private Insurance:	$1.2	$3.4	183%

Revised February, 1987.

The **Chairman**. Mr. Maxwell, the deductible, this $75, was set many years ago. What does the American Association of Retired Persons think about that? Should it be changed or not?

Mr. **Maxwell**. I don't think that we seek a change on that. I think that this is a substantial contribution to the expense under Medicare, and a contribution that our folk are willing to make. I don't think, though, it should be jumped to 150 percent, which would be indicated by the 38.5 percent jump that's being proposed by Medicare.

The **Chairman**. Well, what do you mean, 150 percent? You're saying you don't think it should be jumped to $187.50, if my mathematics is correct. What about $100? I'm not suggesting anything; I'm just asking. When I say it hasn't been increased for a long period of time, I'm reflecting on the fact that most deductibles, whether it's health insurance or car insurance, have certainly been increased over the past few years.

Mr. **Maxwell**. Actually, the individual contribution of $75 really represents, in terms of the additional charges that a physician assesses over and above what Medicare allows, still actually means that the deductible is about $100 to $125.

The **Chairman**. I understand exactly what you mean now.

One thing I don't understand, but I want to be sure to, is that you said "a contribution"—what do you mean, a contribution? You go to the doctor and pay the first $75 that would be subject to Medicare Part B, and you get services rendered for that. Is that what——

Mr. **Maxwell**. Well, if he's a participating physician you get services rendered for that less your deductible.

The **Chairman**. Less your deductible.

Mr. **Maxwell**. But many physicians—I lived in a community in the hills of Tennessee, a fair-sized county, where only one physician on the schedule was a participating doctor. As a consequence, many of our office calls ended up with us paying $10, $15, $20 in addition——

The **Chairman**. In addition to what Medicare covered?

Mr. **Maxwell**. Plus the deductible.

The **Chairman**. All right.

Now, do you think—Dr. Roper says he's got great hope in capitation. I don't quarrel with that but I think it's very slow and I think it only fits certain areas. I also don't really think it's the solution.

Mr. **Maxwell**. We don't look on it as a solution at all.

The **Chairman**. All right. How about this so-called "bundling"? That is, Medicare says, "Well, here is what you would probably do on this type of office call, and we're just going to say that we'll pay you so much for all the tests that you might take for that particular office call, and we're going to pay you on that basis. You bill us and we'll pay you." Is that good sense?

Mr. **Maxwell**. We think that is workable but the problem is—let's talk about the participating physician establishment, a doctor who is a participating physician. We're not certain that there are going to be enough participating physicians who will accept this bundling process, which really is part of the participating physician plan.

I think the other thing is that one of the results of bundling under a participating physician plan might be a partial solution to the malpractice question, because if we establish the procedures that the doctor should do and he does them, then I would think that a court would hold that he had performed his required responsibilities toward the patient.

Stephanie, did you want to comment?

Ms. KENNAN. Senator, the question of bundling—one of the reasons we're seeing physicians unbundle is because they feel that the payments are not fair. We would like to look at bundling as a solution to that, but I think you still need to address the causes of why they are currently unbundling charges.

In our written statement we have also supported utilization of volume controls, which Mr. Maxwell was referring to, and we think that in addition would be something that we could work on together.

The CHAIRMAN. All right. I want to thank you both very much for your testimony. All your prepared testimony will be made part of the record, by the way, and it's very good. Over the weekend I've had a chance to read through it and I've been well instructed on what AARP has been fighting for for a long period of time. I thank you for that.

Mr. MAXWELL. We appreciate your hearing.

The CHAIRMAN. Senator Cohen.

Senator COHEN. Mr. Chairman, thank you very much.

Mr. Maxwell, you indicated in some of your statements that—you used the phrase, "if the projected increase occurs." Are you suggesting that there's another alternative that should be pursued?

Mr. MAXWELL. Well, I would hope that it isn't going to end up as a 38.5 percent increase. Now, is that set in cement right now?

Senator COHEN. Well, if it goes forward, it is.

Mr. MAXWELL. Well, I hope that we can go forward at a little less rapid pace.

Senator COHEN. I also was intrigued with your notion that we shouldn't allow increased reimbursements until we see an increase in health care services. I was wondering, how would you measure that?

Ms. KENNAN. I think our point there, Senator, is that we are seemingly paying ad infinitum and we don't know what the value of the services is. We need to do more studies on patient outcomes. Any volume controls or utilization review you would want to put into place we think needs to be based on this patient outcome, not just cost. You could conceivably have a doctor who has just drawn a more complex set of cases and his utilization may be higher because those cases warrant it. But you need to look at the actual quality of the outcome of the patients receiving it.

Senator COHEN. Well, I think it's a broad statement. In the abstract it's very desireable but as a practical matter—let's suppose you had, as you've indicated, a stable utilization on the part of our older community, but we're all living longer. We have the same number of visits but we just live longer. How would you establish the causal connection, if any, between the type of care you're getting and the fact that you're living 1 or 2 or 3 years longer?

Ms. KENNAN. Well, let me give you a little bit of a more solid, concrete example. Congress recently prohibited the payment of assistant surgeons for cataract surgery, which has been very controversial. There has been no scientific study that showed that patients with an assistant surgeon in cataract surgery fared better or not. It was just a difference or variation in practice. In some places there are more assistant surgeons available to do that kind of work and in other areas there are more highly trained technologists or nurses in the operating room who could do that kind of work.

But in addition to outlawing that, Congress also prohibited the beneficiary from purchasing those services. The reasoning behind that was that the beneficiaries themselves did not understand or have the basis of knowledge to know whether they really, genuinely needed an assistant surgeon in that room.

Ideally, we would like to see some studies on that. I realize we're getting to the point where we're coming down to the wire and we need to actually make some hard decisions. We would like to see those decisions, as many as possible, made on the outcome of what patients are getting for their money and whether that test is really necessary or not. In many cases that's a hard call to make because practicing medicine is not a hard science.

Senator COHEN. Well, I surely know from my past experience. I remember when I introduced a bill to try to establish tax incentives for people to have annual physical checkups. I thought it was really a good idea to get people to become more conscious about getting at diseases before they really take hold, and somehow to encourage people to be more health-conscious. I don't think I ever received more negative mail in my life. Number one, I got it from my constituents who felt my proposal was a bail-out for doctors—giving taxpayers more incentive to go to hospitals and doctors on a more regular basis. And the physicians were outraged because as they said, "there is no standard number of tests that we can perform on anyone at any given time in their lives; there is no standard to measure this by." So I beat a hasty retreat in trying to impose certain standards for doctors to measure up to.

But also, Mr. Maxwell, I was interested in your comment that if we were to set standards under which we were to reimburse certain participating physicians, then the courts might take that into account. Again, that has a sort of surface appeal. On the other hand, if we had a cost-conscious Congress that said "We're only going to reimburse for the following services," I doubt very much whether the courts would be impressed with that in terms of whether you or anyone else were to bring a suit on the basis of a failure of the participating physician to take precautions over and above what he or she would be reimbursed for. I think that that would really not deter the courts in any respect from judging inadequate care harshly.

One final comment, on malpractice—we've heard a lot about malpractice. The Chairman has indicated that there is a serious problem in terms of physicians not segregating out their costs. I think that physicians are doing precisely what insurance companies are doing. They're building a rate structure or fee structure which has no relationship to the groups or the individuals coming in to see them. I point to my own State of Maine, for example. I can't think of a major medical malpractice case that has succeeded in my recent experience, and yet we pay the same high, outrageous rates that many other parts of the country do. Yet it has no relationship whatsoever to the litigation experience of my State. Insurance companies get into the concept of "pooling," and therefore Maine has to pay for other States. I suspect that what physicians are doing is protecting themselves—but not against the senior citizens who may have a lower claims rate than a younger population; they are simply doing what insurance companies are doing.

So we talk about tort reform. I don't think we can separate tort reform from insurance industry reform as well, but we ought to start taking a look at how those rate structures are arrived at.

Mr. MAXWELL. I agree with you, sir.

Senator COHEN. Thank you very much, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Cohen.

Senator Heinz.

Senator HEINZ. Mr. Chairman, I'm going to reserve any questions at this point because we have a number of other witnesses and the hour is growing late.

The CHAIRMAN. Thank you very much for your testimony. It's been helpful to the committee.

Mr. MAXWELL. Thank you, sir.

The CHAIRMAN. The next witness will be Mr. Eric Shulman, Legislative Director for the National Council of Senior Citizens.

Mr. Shulman.

STATEMENT OF ERIC SHULMAN, DIRECTOR OF LEGISLATIVE LIAISON AND RESEARCH DEPARTMENT, NATIONAL COUNCIL OF SENIOR CITIZENS, ACCOMPANIED BY LUCIA DiVENERE, DEPUTY DIRECTOR, LEGISLATION AND POLICY

Mr. SHULMAN. Thank you, Senator Melcher.

I am accompanied today by Lucia DiVenere, Deputy Director of the Legislative Department at NCSC.

I would just say at the outset that we join Mr. Maxwell and AARP in hoping that something can be done about the 38.5 percent increase in the Part B premium before it goes into effect on January 1st. We recognize that there isn't much time, but we do feel—certainly on the basis of the mail and concerns that have been voiced by our own members to us—that something really must be done. I wish I could say that we could try and roll it back all the way, or even roll it back to the 4.2 percent increase in the COLA. I would like to think that that's possible. But at a minimum I would hope that we could at least roll it back somewhat to alleviate some of the financial burdens on the elderly.

Unless Congress acts, older Americans will be required to shoulder an unprecedented 38.5 percent increase in the Medicare Part B premium. This additional cost will prove extremely difficult for millions of older Americans, particularly the 15 million older Americans whose incomes fall below $10,000 a year.

A number of possible explanations have been offered for why the Part B premium is so high, including that services have been shifted to outpatient settings; the population is aging; and that beneficiaries induce demand. HCFA has found that none of these explanations provide a significant rationale for the increase.

According to HCFA, 78 percent of the increase in the Medicare Part B premium is due to growth in program expenditures, most of which is the result of increased prescribing of physician services and tests. CBO agrees with the conclusion, pointing out that higher volume was the primary reason for growth in costs during the fee freeze that ended this year. CBO determined that the growth in costs for physicians' services that exceeds general inflation has resulted almost entirely from increases in the volume of services provided. This may be partly why net physician income rose 31 percent from 1981 to 1986, even through times of Medicare fee freezes.

NCSC rejects outright the contention that physician services are overutilized by senior citizens who get a CAT scan for every headache. Physicians control demand in the health care marketplace and determine the quantity and type of services they will provide. They determine the level of care that each patient needs. Evidence shows that even under fee freezes physicians increased their return under Medicare by performing more—and at least sometimes unnecessary—procedures.

The current Medicare physician payment system encourages doctors to raise their fees on a regular basis and to provide more services than they might otherwise. In essence, the more they charge the higher the accumulated profile on which future fees are based, and the more services they prescribe the more they will be paid.

We believe the problem can be laid directly at the physicians' doorstep, but it is the patient who will pay.

According to HCFA, about 22 percent of the premium increase is due to the replenishment of the contingency fund. The Part B contingency fund is basically the difference between Part B income and expenses. In 1984, when the contingency fund had a healthy surplus, it was allowed to be depleted, partly in order to keep the Part B premium increases low in 1985, 1986, and 1987. Now the contingency fund needs to be replenished. Under the new, current HCFA plan this replenishment would occur over the next few years but still accounts for $1.50 of the $6.90 premium increase. We feel that such a rapid replenishment is inappropriate and unnecessary. Congress should consider phasing this in more slowly, an option that could save seniors as much as $437 million in 1988.

Congress must act to prevent this unprecedented and unfair price increase from going into effect. We hope Congress will measure all attempts to solve the problem of runaway Medicare Part B costs by three standards: access, quality, and affordability of care.

Briefly, our recommendations are as follows.

One, tie the Part B premium increase to the COLA. NCSC supports Congressman Pepper's legislation, H.R. 3291, which would tie Part B premium increases to the cost of living adjustment received by Social Security beneficiaries. The cost of this legislation is $1.7 billion and could be partially offset by requiring remaining State and local employees to pay into the Medicare program and by phasing in the replenishment of the contingency fund over the next 5 years.

Recommendation number two—although this doesn't directly affect the Federal budget, we believe that mandatory Medicare assignment is going to happen and it's going to happen, hopefully, in the near future. NCSC supports efforts underway around the country to prohibit physicians from charging Medicare beneficiaries more than a reasonable price for their services. Beneficiaries pay $3 billion a year for charges above what Medicare considers a fair price. Physicians should not be allowed to charge some patients more than others for the same services just because they think those patients may be able to afford a little more. After all, the average physician makes about $113,000 a year after all expenses, including malpractice, while the average senior citizen lives on only about $8,100 a year.

While mandatory Medicare assignment won't address the basic issue of unchecked growth of services under the Part B program, it would certainly relieve seniors of a very difficult and related burden, that of excess billing.

Other long range solutions—many of the long range solutions were discussed during today's hearings—include pricing physicians' services based on a relative value scale and bundling services in a DRG-type system. All sorts of payment reforms are currently under study and we are delighted by the determination with which these studies are being conducted. It is our strong hope, however, that Congress will not put off efforts to slow or prevent this immediate increase while waiting for long range comprehensive reforms to be put in place.

Thank you.

[The prepared statement of Mr. Shulman follows:]

Executive Director
William R. Hutton
Washington, DC

National Council
of Senior Citizens

President
Jacob Clayman
Silver Spring, MD

925 Fifteenth Street, N.W. • Washington, D.C. 20005 • (202) 347-8800

THE 1988 MEDICARE PART B PREMIUM INCREASE

Statement Presented Before the
Senate Special Committee on Aging

By

Eric Shulman, Director of
Legislative Liaison and Research Department
National Council of Senior Citizens
925 15th Street, N.W.
Washington, D.C.

Mr. Chairman, thank you for giving me the opportunity to present the views of the National Council of Senior Citizens on the scheduled Medicare Part B premium increase. The message behind this increase is simply that physician health care costs are out of control.

Unless Congress acts, older Americans will be required to shoulder an unprecedented 38.5 percent increase in the Medicare Part B premium as of January 1, 1988. This additional cost will prove extremely difficult for millions of older Americans, especially the 15 million older Americans whose incomes are below $10,000 a year. Under this increase, seniors will essentially be paying significantly more and getting nothing new in return--the benefit and their entitlement to it are no different than before the price increase was imposed.

The only net differences resulting from this increase are these: seniors will have fewer dollars in their pockets, physicians will have more dollars in theirs, and Part B will have to dig down deeper into general revenues.

The Major Problem: Increase Volume of Services, Caused by Whom?

A number of possible explanations have been offered for why the Part B premium increase is so high, including that services have been shifted to out-patient settings, the population is aging, beneficiaries induce demand, and formerly unmet health care needs are being met. HCFA has found that none of these possible explanations provide a significant rationale for the increase.

According to HCFA, 78 percent of the increase in the Medicare Part B premium is due to growth in program expenditures, most of which is the result of increased prescribing of physician services and tests. CBO agrees with this conclusion, pointing out that higher volume was the primary reason for growth in costs during the fee freeze that ended this year. CBO determined that the growth in costs for physicians' services that exceeds general inflation has resulted almost entirely from increases in the volume of services provided. (Further, CBO is able to show that the volume of services increases at times when real fees are falling as physicians attempt to keep their incomes rising.) This may be partly why net physician income rose 31 percent from 1981 to 1986, even though times of Medicare fee freezes.

In order to understand the cause of the premium increase, it's necessary to understand the cause of the increase in services. NCSC rejects outright the contention that physician services are "overutilized" by senior citizens who get a CAT scan for every headache. Physicians control demand in the health care marketplace and determine the quality and type of services they will provide. Physicians are the gatekeepers of our health care system and sort out the level of care that each patient needs. Evidence exists to show that, even under fee freezes, physicians have been finding ways to increase their return under Medicare by performing more and sometimes unnecessary procedures.

To most patients, it would seem like more health care is good health care. But this is not always the case. If you look at the situation in another setting, it's easy to see that more is not always better. If you bring your car to the repair shop, for example, the repairman can add to his income easily, even if he doesn't raise his rates, by simply doing more and more to your car--some of which may be necessary, some may not, but all of which you'll end up paying for in the end.

With Part B, it's the same situation in a different setting. The current Medicare physician payment system encourages doctors 1) to raise their fees on a regular basis and 2) to provide more services than they might otherwise. In essence, the more they charge, the higher the accumulated profile on which future fees are based, and the more services they prescribe, the more they will be paid.

The problem can be laid directly at the physicians' doorstep, but it is the patient who will pay for it.

The Second Problem: Replenishment of the Contingency Funds

According to HCFA, about 22 percent of the premium increase is due to replenishment of the contingency fund. The Part B contingency fund is basically the difference between Part B income and expenses. In 1984, when the contingency fund had a healthy surplus, it was allowed to be depleted, partly in order to keep Part B premium increases low in 1985, 1986, and 1987.

Now, the contingency fund needs to be replenished. Under the current HCFA plan, this replenishment would occur in one year, accounting for $1.50 of the $6.90 total premium increase. We feel that such a rapid replenishment is inappropriate and unnecessary. Congress should consider phasing in this replenishment over five years, which would save seniors $437.3 million in 1988.

Cost of Physician Services to Beneficiaries

According to the Census Bureau, the median income of people 65 years old and over was $8,154 last year, $11,544 for men and $6,425 for women.

Already, seniors' costs for physician services are very high. Beneficiaries pay more than $5 billion a year in Part B coinsurance, approximately $3 billion a year in excess charges, and about $1.7 billion in the Part B deductible.

As a result of this increase, enrollees will pay nearly $298 in 1988 for Part B premiums, $83 more than in 1987. This 38.5 percent premium increase will use up almost one-third of the 4.2 percent COLA that the average senior citizen will receive in 1988. About 3.4 million of the lowest-income elderly have some protection against Medicare premium increases--either through Medicaid or the hold harmless rule under which the dollar increase in a beneficiary's premium can never exceed the increase in his Social Security benefits. But, according to CBO, another 2.9 million elderly with incomes of less than $5,000 and 4.8 million elderly with incomes of less than $7,400 a year will not be protected by either Medicaid or the hold harmless provision.

Possible Solutions

Congress must act to prevent this unprecedented and unfair price increase from going into effect. The increase is simply much too severe to allow it to go through without making an attempt to bring it to reasonable levels. We hope Congress will measure all attempts to solve the problem of runaway Medicare Part B costs by three standards: access to care, quality of care, and affordability of care.

Recommendation #1

Tie the Part B increase to the COLA. NCSC supports Congressman Pepper's legislation, H.R. 3291, which would tie Part B premium increases to the cost-of-living adjustments received by Social Security recipients. It's basically unfair, we believe, to require older Americans to pay more than they are able. From 1975 to 1983, while the COLA increased by seven percent a year, Part B costs increased by 17 percent a year. As the Part B increases continue to take larger chunks out of the COLA, beneficiaries will have fewer resources available for other necessities of life that also increase in costs each year. This legislation would ensure equity and ensure that cost-of-living increases are available to beneficiaries to meet the increased costs of living and not just shifted over to ever-higher physician payments.

The cost of this legislation, $1.7 billion, could be partially offset by requiring remaining state and local employees to pay into the Medicare program and by phasing in replenishment of the contingency fund over five years. These two payment sources would pay for all but just under $500 million of the cost of Congressman Pepper's bill.

Recommendation #2

Mandatory Medicare assignment. NCSC supports efforts underway around the country to prohibit physicians from charging Medicare beneficiaries more than a reasonable price for their services. Beneficiaries pay $3 billion a year for charges above what Medicare considers a fair price.

It isn't fair that physicians should be able to charge more than a reasonable price. Neither is it fair that physicians should charge some patients more than others for the same services, just because they think those patients may be able to afford a little more. Afterall, the average physician makes $113,000 a year after all expenses, including malpractice, while the average senior citizen lives on only about $8,100 a year.

While mandatory Medicare assignment won't address the basic issue of unchecked growth of services under the Part B program, it would relieve seniors of the very difficult and related burden of excess billing. Under the current system, physicians pad their incomes and pass along the bill to seniors in many ways. Mandatory Medicare assignment would remove one of the most obvious and unfair methods of doing this.

Recommendation #3

Capitation. The Administration has proposed Medicare

PPOs as a way to control for unnecessary prescribing of physician services. In our meetings with Dr. Roper, we urged him to go slowly with this approach and we would hope the Congress would similarly proceed with great caution. We have two major concerns with this concept.

First, we are concerned that senior citizens should not be penalized if they choose to remain with a lifelong physician who may not choose to join, or may not be eligible to join, a Medicare PPO. HCFA has proposed that beneficiaries who go to PPO physicians should pay lower coinsurance levels (10%) and beneficiaries who go to non-PPO physicians would pay higher coinsurance charges (30%) than the current 20 percent coinsurance rate. Under this scheme, while beneficiaries would still theoretically have the freedom to choose their physicians, the financial penalties would be so great on many beneficiaries as to leave them with no choice at all.

Second, under the PPO arrangement, physicians would have incentives to provide less care than under the current system. To some extent, this is just what the doctor ordered, so to speak. But our concern lies with the fact that it is extremely difficult today to determine where to draw the line between necessary and unnecessary procedures and tests. Under any cost-containment arrangement, quality of care must be protected and patients must not be denied needed health care services.

Other long-range solutions include pricing physician services based on a relative value scale and bundling services in DRG-type payments. All sorts of possible payment reforms are currently under study by OTA, PPRC, and DHHS and we are delighted by the progress that is being made and the determination with which these studies are being conducted.

It is our strong hope, however, that Congress will not put off efforts to slow or prevent this immediate increase while waiting for long-range, comprehensive reforms to be put in place.

Conclusion

The 38.5 percent increase in the Part B premium will cause significant financial harm to millions of older Americans. Something should and must be done before the end of this session to prevent the full effect of this increase from going through. We urge the Members to consider legislation along the lines of Congressman Pepper's bill and to keep in mind the basic issues of fairness, access to care, quality of care, and affordability of care.

The **Chairman**. Thank you very much, Mr. Shulman.

First of all, let's start with that $8,100 figure that you cited. Are you stating that that is the average per capita income for senior citizens?

Mr. **Shulman**. That's the average income of senior citizens in the country.

The **Chairman**. How many of those people would not pay any increase? How many senior citizens——

Mr. **Shulman**. Would not pay any increase as a result of the stricture against Social Security benefits being lowered? I think that it was AARP that estimated approximately 400,000 to 500,000, but I'm not sure. We don't have a figure on that, but my understanding is——

The **Chairman**. Less than a million out of the 31 million?

Mr. **Shulman**. About 400,000, I believe, is the figure of the number of people whose Social Security checks would drop as a result of the premium increase, but will not because of the law which says that Social Security checks cannot drop.

The **Chairman**. Among your membership do you find this to be a very worrisome problem, this $7 per month increase?

Mr. **Shulman**. There's no question that it's a serious problem among our membership. I mean, it unavoidably gets mixed up with past Part B premium increases, with past restrictions on tax benefits for the elderly, on the catastrophic supplemental premiums—all of these things taken together, I think, reflect a real effort to diminish the incomes of—not, perhaps, the poorest of the poor who may be covered by Medicaid, but people of low and moderate incomes are being hurt by these various proposals. No doubt about it.

The **Chairman**. Older Americans are becoming very frustrated with what is happening to them. Health care costs are rapidly increasing, faster than the cost of living adjustments they might have, on their pensions or Social Security checks.

Mr. **Shulman**. Yes, sir. There's no doubt about it. We are hearing from our people loud and clear that a 38.5 percent increase in the Part B premium is outrageous. They are urging us to try to do something about it, and we hope that even if it's a temporary measure or even if it's not the perfect long-term solution, we ought to try to find some revenues to roll back. We're not suggesting that we want to fight a deficit battle here, but it would certainly be important for us to look at short-term, immediate ways to at least roll that 38.5 percent increase back by some amount.

The **Chairman**. Well, I tend to agree that it would make sense to not accept the entire $6.90 increase and to try to reduce it. We'd have to change the law to do that. I think it should be reduced not only because, number one, it is a staggering increase percentagewise but number two, because we ought to be doing something here in Congress to control health care costs for older Americans. Both the House and the Senate passed catastrophic legislation that will be budget neutral and financed entirely by beneficiaries.

We have discussed four different ways of holding down Part B costs; some are prioritized by HCFA and some are recommended by your group or AARP or others. I think Congress ought to react and do something now. If we accept only a part of that increase for

Part B, I think there is a stronger possibility that Congress will act to hold down these costs for everybody.

I don't believe capitation is much of a solution. I think it's time that we move, and that means Congress does something. I think not permitting the entire increase to go into effect would put pressure on Congress to do something about growing Part B expenditures. I think you will see, Mr. Shulman, that we in Congress will take some steps to reject part of that increase, and will begin to address how we are going to control costs. I don't think it need be one of antagonism between the medical profession and the physicians and their patients. I think it can be worked out in a very practical manner and that the physicians would be delighted if we got rid of some of this paperwork.

Mr. SHULMAN. Right.

The CHAIRMAN. I believe costs could be reduced if we simplified the paperwork involved in processing Part B claims. What relevance has complicated and confusing paperwork to good medicine? If it's relevant to the good practice of medicine and a physician's care of a patient, then it may be necessary. However, I don't believe it does and I haven't found any number of physicians that believe it does. I asked Doctor Roper earlier, who created this monster? He did claim part on behalf of HCFA. He also seemed to indicate that carriers and insurance companies were guilty. I am sure that as long as Congress allows that to exist, we are also guilty. I feel some responsibility and I think this committee feels some responsibility. I believe you may see some action out of Congress before the first of the year.

Senator Heinz.

Senator HEINZ. Mr. Chairman, I have no questions.

Well, I do have one. I listened carefully, Mr. Shulman, to your ideas about how we can avoid the increase or at least mitigate it somewhat this year. I listened also to your proposal about mandating assignment. But it strikes me that neither of those proposals, meritorious as they may be, have anything to do with the underlying problem, which is the vast increase in utilization of Part B benefits. Do you have anything to say about that?

Mr. SHULMAN. Well, as far as mandatory assignment is concerned, I certainly am not proposing that as action that should be taken in this session.

Senator HEINZ. I understand that. I'm concerned about what any of us—the administration or Congress—should do about the vastly increasing utilization of Part B benefits. We've had several lengthy discussions as to why those benefits are being utilized. Sometimes it's due to the physicians. Sometimes it's due a shift from to Part A. There are a variety of reasons. The fact is that the underlying increase in Part B appears to be almost inevitable.

Mr. SHULMAN. Yes.

Senator HEINZ. We can hold it back a little. We can complain about HCFA management, which I have done. But it's like complaining about the tide. All we're complaining about really, is that the waves are a little too big today. The true problem is that we have this tide rising on us and we need to do something to get the moon to move; otherwise I think the tide is going to swamp us.

Mr. SHULMAN. I agree with you, Senator, and I think it is going to be important to look at many of the solutions that have been discussed today, whether it's a relative value scale or capitated payments or a variety of other types of approaches. But that's simply not going to happen in the next 2 months. I think we basically have to January 1 to try to address this problem even in just a short-term, limited sort of way. I know it won't necessarily contribute to the underlying problems of the Part B premium increase but at the very least it will relieve the burdens that elderly people, particularly low-income elderly people, will face as a result of it. I think we need to do both.

Senator HEINZ. Mr. Chairman, I might just add that Mr. Shulman is accompanied by a former member of the Committee on Aging's majority staff, Lucia DiVenere.

Lucia, it's nice to see you. Thank you for being here. We wish you were still on our staff. [Laughter.]

Mr. SHULMAN. You're not going to get her back, anyway.

The CHAIRMAN. We trust, Lucia, you are contributing to the cause in your present position.

Mr. SHULMAN. Definitely.

The CHAIRMAN. Senator Cohen.

Senator COHEN. Just one question, Mr. Shulman. What portion of the Part B premium should be borne by the beneficiary? Right now it's about 25 percent.

Mr. SHULMAN. Well, of course, a few years ago it sort of dropped back to 20 percent or 21 percent and it was only through the reconciliation legislation that the requirement was placed at 25 percent.

I guess it's hard for me to put a specific percentage to it. I think we are probably more or less in the ball park in general terms, but I would certainly like to see it reduced somewhat, if only to compensate for the current Part B premium increase.

Senator COHEN. What's your reaction to the proposal by Doctor Roper about trying to direct beneficiaries to those physicians who are more conservative in their treatment?

Mr. SHULMAN. Well, I suppose it depends on how exactly they are directed to those physicians. I am disinclined to support any kind of proposals that would effectively force people to go to physicians that they don't want to go to by way of reduced co-payments for going to certain physicians as opposed to others.

I have those concerns in terms of specific proposals like reducing co-payments to HMO's or PPO's because I think people do have a right, and elderly people do want to be able to go to the physicians that they want to go to. That freedom is important.

Senator COHEN. Thank you.

The CHAIRMAN. Thank you very much, Mr. Shulman and Ms. DiVenere.

All right, our next witness will be Doctor Risa Lavizzo-Mourey from the University of Pennsylvania School of Medicine and the Wharton School.

Senator HEINZ. Mr. Chairman, I want to thank you for three things. First, you pronounced her name correctly; second, I thank you for adding her to the witness list; and third, I thank you for accommodating her schedule. Doctor Lavizzo-Mourey has to attend to her rounds at 3 o'clock this afternoon in Philadelphia and she has to catch a 1 o'clock flight, so I'm much indebted to you, Mr. Chairman.

The CHAIRMAN. All right. Thank you.

Please proceed, Doctor.

STATEMENT OF RISA LAVIZZO-MOUREY, M.D., FACULTY, UNIVERSITY OF PENNSYLVANIA SCHOOL OF MEDICINE AND THE WHARTON SCHOOL

Dr. LAVIZZO-MOUREY. Mr. Chairman, members of the committee, I am Doctor Risa Lavizzo-Mourey of the University of Pennsylvania where I am an Assistant Professor of Medicine and also an Assistant Professor of Health Care Systems at the Wharton School. I am also a Fellow of the Center for the Study of Aging and a Senior Fellow at the Leonard Davis Institute of Health Economics.

My practice in medicine as a board-certified internist is devoted exclusively to the care of the elderly. Therefore, I come to you today as a clinician who is concerned about rising health care costs but who is also concerned that any solutions that we choose now should not limit our ability to have high-quality care for all of our elderly into the 21st century.

What precipitates these hearings is the rise in the Part B premiums and our desire to limit these increases in the future. But as we look at some of these specific proposals we have to keep in mind that there's an underlying issue. I'd like to just address that underlying issue, as others have today.

The increase in cost for physician payments is multifactorial. It is due to the increased number of practicing physicians; the changes in physician billing practices—that is, un-bundling; the shift of medical care from the hospital to the outpatient setting, and it's also due to the increase in technology. The demographic trends indicate that there are more beneficiaries, and these people are aging.

So when we look candidly at the deficiencies we can see that there is more than enough responsibility to share among all of us. To quote the philosopher Possum Pogo, "We have seen the enemy and he is us." So I urge you not to put undue burden on the beneficiary—in this case, the elderly, who I can assure to you as one of their physicians and advocates already carry a large portion of the burden for the deficiencies in our health care system. The very old require more services than the young and younger elderly. As a geriatrician I can tell you they require more time because they have more chronic illnesses and functional disabilities and they have to face these with limited family and financial resources. Yet studies indicate that elderly tend to underreport their problems and to delay seeking medical attention for such serious problems as cancer, dementia and congestive heart failure.

Fortunately, the medical community has begun to respond with a change in the standard of care. We know that some of these changes in assessment procedures are cost-effective. Let me give you an example from my practice that will illustrate the point.

Ten years ago when I participated in my first evaluation of a patient with Alzheimer's disease, it was done in a hospital over a 4-day period. The only cost to Part B of Medicare for that evaluation would have been those four physician visits. The evaluation that I began last Friday on a patient who probably has Alzheimer's disease will require that patient come back to the practice four or five times to see physicians, nurses, social workers, and will also involve a well-chosen, individualized battery of tests. Clearly, the cost to Part B Medicare for the evaluation in 1987 is going to be higher than that 10 years ago, yet we do know that these kinds of assessments are cost-effective and reduce overall health care costs, principally by reducing nursing home placements. So my patient, I hope, will have not only a diagnosis but a plan of care that will improve her quality of life and will help reduce the probability that she enters a nursing home.

In this instance we are fortunate in knowing that this is a cost-effective practice. However, that is often not the case with services from which physicians must decide. It is a difficult balance for us all—physicians, legislators, payors—to compromise between cost and quality, especially when we do not always know how to measure quality. And if it's a difficult balance for us, it is a nearly impossible one for the elderly who must make these sorts of decisions which will affect their quality of life and their quality of care without medical skills and without adequate information.

We don't really know what the effect will be on our elders of a proposal that forces elderly patients who tend to underreport and who have chronic illnesses, to make health decisions based on financial constraints, but we do know that the poor do forego necessary services when financial barriers are placed in their paths.

So let me conclude by saying that the reasons for rising health care costs are complex. The problem is related to volume of services in part, but we need to better understand cost-effective medicine. We need to develop consensus on what is cost-effective and we need to better educate physicians on cost-effective practices and, finally, to better educate beneficiaries before we can ethically place more burden on the elderly.

Thank you.

[The prepared statement of Dr. Lavizzo-Mourey follows:]

TESTIMONY TO THE SPECIAL COMMITTEE ON AGING
OF THE
UNITED STATES SENATE

RISA LAVIZZO-MOUREY, M.D., M.B.A.

University of Pennsylvania

NOVEMBER 2, 1987

Mr. Chairman and members of the Committee, I am Dr. Risa Lavizzo-Mourey of the University of Pennsylvania where I am an Assistant Professor of Medicine in the School of Medicine, an Assistant Professor of Health Care Systems in the Wharton School, a fellow of the Center for the Study of Aging, and a Senior Fellow of the Leonard Davis Institute of Health Economics, a university-wide health services research and health policy organization made up of physicians, economists, decision scientists, lawyers and management scientists. My medical practice as a Board-Certified internist is exclusively with the elderly as outpatients and as inpatients of the Hospital of the University of Pennsylvania. I am also Medical Director of Elmira Jeffries Memorial Home, a 180-bed teaching nursing home in Philadelphia.

I come before you today not as an official of the Federal Government, nor as a representative of a national provider organization such as the American Medical Association or a national consumer group but as a physician beginning a career in academic medicine who concurrently pursues teaching and research in both schools of medicine and business. I am here because of my concern for rising health care costs. I seek short-term solutions. However, I am equally concerned that any short-term solutions to the cost problem permit long-term strategies to maintain quality care through cost-effective health services of all our elderly citizens in the 21st century.

As a constituent of Senator Heinz, I no doubt share many of his concerns. Therefore, I am pleased to be able to comment on some of the methods proposed to limit Medicare Part B cost.

OVERVIEW OF THE PROBLEM

These hearings have been precipitated by the need to to increase premiums for Part B of Medicare and a desire to limit future increases. Although the dollar amounts may seem small to some, the percentage rise is very dramatic. While there are specific proposals being considered, I will begin by discussing the underlying issue. The underlying issue is one of volume and price of services in the quasi-market, partially regulated economy of health care, in which conflicting incentives and their response account for rising utilization and cost inflation. Market theory argues that both will be controlled through supply and demand. Health care, as we all know, does not follow the principles of a market economy. Therefore the Physician Payment Review Commission, the Health Care Financing Administration, the Congressional

Office of Technology Assessment, among others are looking for ways to manage volume and price of services in the best interest of the patient, physician, and the society.

A colleague at the University of Pennsylvania and Commissioner on the Physician Payment Review Commission, Dr. John Eisenberg provided a detailed review of physician's fees in his testimony before Congress. The increased number of practicing physicians; changes in physician billing practices (unbundling); the shift of medical care from the hospital to the outpatient setting; and the availability of new technology are all factors in the increased services used by Part B beneficiaries. Further, demographic shifts mean that there are more beneficiaries and that the elderly as a group are aging. Thus, the reasons for this two decade long steady rise in costs are multifactorial.

When one looks candidly at the deficiencies in health care in contemporary America and examines the roles of all involved, there is more than ample responsibility to share among all of us -- patient, provider, payor, and public. To quote the philosopher possum, Pogo, "We have met the enemy and they is us." Therefore, let us be careful not to put the burden for correcting cost escalation on the victims of disease, in this instance the ill elderly, who I can attest as one of their physicians and advocates, experience more than their share of the deficiencies in the American health care enterprise.

ANALYSIS OF ISSUES

We are attempting to control medical costs under the fee-for-service mechanism for reimbursing physicians. Historical precedent argues for the continued use of fee for service as the primary instrument for allocating medical resources. Although this is the dominant method for paying physicians in our society, there is also considerable experience with salary (fee for time) and capitation (fee per patient). As one of my colleagues, Dr. William Kissick, of the Leonard Davis Institute of Health Economics often points out, there are disadvantages as well as advantages for each of these mechanisms for the three principle -- patient, physician, and the society or its constituent institution. I concur, and feel very strongly that we must address these issues in our conceptualization of the long-term future while searching for incremental gains.

If I am fortunate enough to achieve my predicted life span, my professional career will extend to the year 2025 after which I can look forward to 15 years of retirement. I must confess I think more about the years and accomplishments of my professional activities than I do anticipating 15 years in retirement nurturing at least a half-dozen chronic diseases. I mention this because I would like my testimony to be responsive to the concerns of Senator Heinz and his constituents who are senior citizens in 1987, 1988, 1989, and 1990 as well as my fellow senior citizens between the years 2025 to 2040. A glimpse at demographic projections should be sobering as we consider solutions for today's cost problem. The proportion of our society needing services will get larger in comparison to those in the work force paying for the services.

The very old receive more medical services than younger elderly, 8.4 visits per year for those over 75 as compared to 7.4 for those betwen 65 and 74. As a geriatrician, I can tell you that these eldelry require more time because they have chronic diseases (averaging between five and eight chronic diseases), and have more functional disabilities (30 percent requiring assistance with personal care) in the face of limited financial and family resources. Yet studies have indicated that these elderly typically under-report their symptoms and delay seeking medical attention for such serious problems as cancer, congestive heart failure, and dementia.

Fortunately, the medical community is recognizing these special needs and the standard of care is changing as a result. Interdisciplinary assessments of these frail patients are labor intensive and increase utilization. However, these assessments improve outcomes and reduce later health care costs principally related to nursing home placement. These assessments are examples of how some changes towards increased utilization have led to increased quality of care as well as how shifts from the inpatient setting to the outpatient setting can affect utilization. Moreover, these services emphasize cognitive skills of physicians, more than technical procedures. The current disparities in reimbursement between cognitive skills and technical procedures provides a disincentive for physicians to provide the services the elderly often need most, In addition, cognitive services are difficult to evaluate with retrospective utilization review.

Let me use a patient history from my own practice to illustrate the point. Ten years ago when I participated in the evaluation of my first patient with Alzheimer's disease, it was done in the hopsital over a four-day period, and the thrust of the evaluation was aimed at uncovering reversible causes of dementia. That evaluation, with the exception of the four physician visits, would not be included in Medicare Part B. The evaluation of a patient who probably has Alzheimer's disease that I began last Friday will require that the patient make four or five visits to physicians, nurses, social workers and psychologists and will also require a carefully chosen and individualized battery of tests. In the end, the patient and her family will have not only a diagnosis but also a plan of care to promote better quality of life and reduced probability of entering a nursing home. Yet, the 1987 evaluation consumes more Part B resources.

In this instance, we are fortunate in knowing that these kinds of assessments are, in fact, cost-effective. However, we do not have the clinical cost-effective information on many kinds of services delivered. Therefore, as we view these solutions, we must be ever mindful of their effects on cost and quality, especially where there is insufficient information on where long-term benefit may be thwarted. It is easy to reduce costs at the expense of quality; conversely increased utilization can mean improved quality.

If this is a difficult balance for physicians, legislators, third-party payors, and the Health Care Financing Administration, it is a nearly impossible one for the elderly who must make the cost quality trade-off with only a lay person's knowledge. Solutions which provide financial incentives to elderly for choosing cost-efficient providers force them to treat health care as they would any other product and make decisions which have implications for the quality of their care and the quality of their life without having the medical information and skills necessary to make those decisions. Indeed, it has been shown that financial incentives can influence the type of plan chosen, and the utilization of medical services. While we do not know what the impact would be on old people with multiple chronic illnesses and the tendency to under-report those illnesses, financial barriers have been shown to decrease the use of necessary medical services by the poor. In short, it is premature to increase further the elderly's risk through financial incentives.

Rising health care costs and the increased volume of physician services being provided are complex problems. Solutions require better understanding cost-effective medical practices; consensus development among health care providers regarding cost-effective medical practices, better education of physicians and finally, education of beneficiaries. Only then can we ethically ask our elderly to take on a greater financial burden for the rising health care costs in this country.

COMMENT ON PROPOSALS

Health Care Financing Administration has outlined four initiatives to address the control of volume and cost of services provided by physicians under Part B of Medicare. I shall comment on each of these.

(1) **Freeze fees for non-primary care services.** This addresses only one side of the cost/volume equation. Therefore, one would expect volume to increase. If the size of the fee remains constant, but the volume increases, there is still a rise in overall expenditures.

(2) **Expand utilization review by insurance companies that contract to administer Medicare.** I recognize the value of utilization review, particularly prospective review based on physician consensus which is possible in organized settings. Retrospective reviews often disallow

payments and the cost falls as a burden on the patient who consumes the services rather than the provider who orders or provides the service. Furthermore, prospective utilization review based on group consensus has the advantage of being able to consider appropriately cognitive services.

(3) **Establish a cap on Medicare expenditures by particular geographic areas.** Intuitively, this would appear viable for certain services based on procedure but extraordinarily complex for the cognitive services that constitute primary care. More importantly, however, it forces the rationing of medical care.

(4) **Use financial incentives to encourage Medicare beneficiaries to select preferred providers who practice efficient medicine.** Preferred Provider Organizations offers a mechanism for influencing volume and cost of services by contracting for referral of patients in exchange for a discount on price. It is suggested by some observers that if successful, be influenced in their selection through variable co-payments or co-insurance. For many, it would mean disrupting longstanding doctor-patient relationships. Moreover, at present, beneficiaries seldom have the information necessary to choose providers. One wonders what criteria patients would use for selecting preferred providers in a complex market which even sophisticated researchers have difficulty describing and analyzing.

In the short term, freezing of fees and expanded utilization review will probably meet the priority of cost control. Having said this, I would reaffirm my conviction that tinkering with the fee system will have problems with equity and quality of care. Financial incentives for preferred providers offer short-term gains and if linked to a long-term HMO strategy look to the 21st century, which is upon us. Experimentation with caps in payments for technology-based services with geographic areas developing high preferred provider organization penetration could be consistent with that strategy. Each of the HCFA's proposals can provide a short-term solution but run the risk of sacrificing cost to equity and quality of care and may increase the elderly's financial burden.

In closing, I would emphasize the complexity of the interrelationships between fees, volume, quality, patient needs, and cost-effectiveness. Further, all of the stakeholders in the health care enterprise share responsibility for the problem. It is imperative not to place the burden of such a complex societal issue on the backs of patients who have the least expertise with which to respond.

The CHAIRMAN. Thank you very much, Doctor.

I would like to refer to the part of your testimony that addresses the evaluation and treatment recommendation of the Alzheimer's patients and compares a patient of 10 years ago with a patient today.

Can you just tell me how you view the change over the 10 years in treating Alzheimer's patients? How has it improved? Is it better coordinated between you, as an internist, and other specialties?

Dr. LAVIZZO-MOUREY. I think that's one of the ways it's changed. Ten years ago most of our evaluation and our practice was aimed at understanding whether or not the person in fact had Alzheimer's disease or some other disease that we thought was more treatable. Today, much of the evaluation and much of the plan we develop is aimed at helping the patients and their families cope with this devastating disease. And that's true of many of the chronic diseases that the elderly face. It's this management plan that takes a large amount of time and the large number of visits in order to develop.

The CHAIRMAN. How many does it take?

Dr. LAVIZZO-MOUREY. Well, at least four or five.

The CHAIRMAN. And 10 years ago it wasn't organized that way?

Dr. LAVIZZO-MOUREY. Ten years ago the norm or the standard of practice was not to have an interdisciplinary assessment where the different aspects of care could be approached by professionals in their respective areas, so that you wouldn't necessarily have a nurse advising families and patients on areas that fall within the expertise of nursing as a part of that evaluation.

The CHAIRMAN. Doctor, your specialty is internal medicine?

Dr. LAVIZZO-MOUREY. Yes, that's correct.

The CHAIRMAN. Is it your experience that you are the first physician to diagnose Alzheimer's in the average patient?

Dr. LAVIZZO-MOUREY. Yes, I am the person who has the long-term relationship with that patient and I see the early changes.

The CHAIRMAN. Are you indicating that what we can do to help somebody with Alzheimer's disease when it is initially diagnosed may well save Medicare a huge amount of money but, more importantly, save the patient a huge amount of confusion and suffering by laying out a program that may keep the patient out of a nursing home or some other type of institutionalization? Is that correct?

Dr. LAVIZZO-MOUREY. That's the point I'm making and I think there are several randomized, controlled trials that support that point.

The CHAIRMAN. Does Alzheimer's disease per se lend itself to what we have been calling "bundling," of services for purposes of reimbursement? Perhaps it doesn't lend itself to that sort of plan.

Dr. LAVIZZO-MOUREY. The diagnosis and development of care for a patient is necessarily individualized so if there are things in one's history that would lead you toward a different group of tests, it would be folly to have the same "bundle"—or same group of tests—for all the patients.

The CHAIRMAN. I understand perfectly. It doesn't lend itself to the so-called "bundling." Thank you very much, Doctor.

Senator Heinz.

Senator **Heinz**. Mr. Chairman, thank you.

Doctor Lavizzo-Mourey, I noted on page 3 of your testimony where you said, "the medical community is recognizing these special needs and the standard of care is changing as a result." Your emphasis on the change in standard of care, I gather, has special relevance to those of us who are concerned about cost increases in the Part B program, which is only a segment of all of the costs borne either by the Federal Government or by the beneficiary or by others in providing health care to beneficiaries.

Is it your concern that a cost control approach that would lock in standards of practice would lock out better treatment?

Dr. **Lavizzo-Mourey**. That is precisely my concern, Senator. We are just beginning to understand some of the specific problems of the elderly and how, as a medical community, we have to respond to those problems. If there are policies in place that either through review process or through prior mandates don't allow this type of development and change in care for the elderly, I think we've done them a tremendous disservice.

Senator **Heinz**. Are you also suggesting—and I don't know that you've said this—that the inability of enough people or practitioners in the medical profession to change, to stay up to date, to apply the latest and most cost-effective techniques, may also be a problem in the kind of cost increases we're having?

Dr. **Lavizzo-Mourey**. The way things are currently set up there may be disincentives for some people to make those changes and many practitioners do not know how to increase the cost-effectiveness of a practice. So, yes.

Senator **Heinz**. What's the best example of that? One that comes to my mind is a procedure called "angioplasty" where, as opposed to coronary bypass surgery, you can do everything that coronary bypass surgery will do with the exception of one particular artery that is involved. Is that a good example?

Dr. **Lavizzo-Mourey**. Well, with coronary angioplasty there are certain types of lesions that one can't treat that way. But in general I think that we have to view technology as being able to substitute for other kinds of technology or being able to compliment it. You have a very good example of a technology that has the potential for substituting another one, and I think that is analogous to the development in the care for the elderly. Some of the things that we are doing now will, down the line, substitute for other kinds of tests and hopefully lead to better outcomes.

Senator **Heinz**. If we were to say,"My goodness, you've got a tremendous resume. You're an M.B.A., you're a doctor, you're a geriatrician, you're the best qualified person to come before this committee—or serve on it, perhaps" "We want to toss you the ball." If we said, "We'd like you to design a system of paying for patient care that will permit the necessary changes and improvements and the substitution of visits for days in the hospital," what would you propose?

Dr. **Lavizzo-Mourey**. I think managed care settings where groups of physicians and managers can develop a consensus regarding what the appropriate kind of care is for a particular age group or a particular group of people with a certain severity of illness is the best method we have available to us now for approaching that problem.

Senator HEINZ. Managed care settings might be a very broad way of doing it, but how would we reimburse for it? Should we do it the way we're doing it now which is basically fee-for-service under Part B? Should we do it on some kind of a DRG basis, as the administration is proposing? Should we do it on some modified basis of fee-for-service with some kind of cost controls? Or should we have incentives for preferred providers?

Dr. LAVIZZO-MOUREY. I think—let me——

Senator HEINZ. Or something else?

Dr. LAVIZZO-MOUREY. I think that DRG's and an overall capitated mechanism within the context of being able to allocate those resources among the patients according to need is very attractive. I'm concerned about a preferred provider arrangement because it really does put the burden on the elderly person to make decisions that one needs to understand quality of care in order to make. I don't think we as researchers and as physicians and legislators really understand quality, so therefore I'm very concerned that the elderly probably don't as well.

Senator HEINZ. Administrator Roper indicated, when I asked him about quality of care that our current standards or ability to evaluate care are very rough, and that it would take at least 2 more years to develop what he termed to be an appropriate quality assurance system.

If we were to hold you, as a clinician, accountable to a particular standard of practice, what factors would you give us as the most accurate and fair view of your care practices? Would it be number of visits, treatment choices, patient outcomes? What would those factors be?

Dr. LAVIZZO-MOUREY. I think all of those are important, but patient outcome for me is really the bottom line. We have to choose outcomes that are sensitive to the particular patient. Mortality or the number of hospitalizations are relatively insensitive measures. For many elderly, failure to further decline in their functional status is an appropriate outcome to measure, but we need to be able to define the outcomes relative to the population groups about which we are speaking.

Senator HEINZ. Doctor, thank you very much. It's really a pleasure to have someone not only from my home State but someone who is very knowledgeable and who can marry a variety of cost control concerns with the practical knowledge of a person who is on the firing line, having to make clinical and medical decisions every day of the week. Your testimony has been very valuable and I thank you for sharing your expertise with us.

Dr. LAVIZZO-MOUREY. Thank you for giving me the opportunity.

The CHAIRMAN. Senator Cohen.

Senator COHEN. Thank you very much.

I'll try to cut my comments short so you can make your plane or train and get back to Philadelphia.

Doctor, as I understand your testimony, you said that basically we've got more patients today; those patients generally are older; older patients have more chronic complaints; they tend to wait longer for treatment; their condition requires more complex treatment; and finally, they need more sophisticated and costly technology to carry out the treatment that is necessary. Right?

Dr. Lavizzo-Mourey. I would agree with all but the last. I don't think we always need more sophisticated and costly technology. We may need to apply that technology differently.

Senator COHEN. I think you indicated that the technology is becoming more sophisticated and that technology is more costly? It costs more to buy that equipment today than it did 10 years ago?

Dr. LAVIZZO-MOUREY. Yes.

Senator COHEN. Okay.

I guess the question I have is—the Chairman has indicated that perhaps the way to force Congress to take action is to delay the proposed 38-plus percent increase in the cost of the premium. From what I hear you saying, maybe Congress shouldn't take any action until we understand what such an action is going to produce. In other words, we might be taking a legislative action without knowing whether it will produce the kind of desirable results that we're all seeking.

Dr. LAVIZZO-MOUREY. Well, I think that we do have to take some actions to try and hold down health care costs. What I'm trying to say, Senator, is that I think that the actions that we take today have to have a potential to be built into more long-term strategies that will not limit us. And I think that if we begin to choose particular kinds of packages or bundling and particular kinds of preferred provider groups now without a view of how those might grow into something that emphasizes quality, we may be doing a disservice. That's the thrust of what I wanted to convey.

Senator COHEN. Well, I agree with you. But the question that we have is—if we take legislative action before understanding where that will lead us, how do we in the meantime hold down the costs without jeopardizing the program itself?

Dr. LAVIZZO-MOUREY. If we combine some of the proposals that were mentioned, I think that we can begin to control costs without further having a detrimental effect. For example, if we merely have a price freeze on physicians' payments, volume is likely to go up; however, if we use the opportunity to also have increased peer review and to make that peer review more of a prospective process, more of a group consensus process that takes into account some of the factors that I've discussed today, I think that we are moving in the direction that will both limit costs and develop a long-term strategy.

Senator COHEN. You also indicated that, as far as education is concerned, we either have the choice of paying more now and—you hope—paying less later. In your experience, is there any consensus within the medical community as to what types of treatment are generally satisfactory for particular age groups?

Dr. LAVIZZO-MOUREY. Unfortunately, there is currently a lot of disagreement on that. We have not looked at many of the preventive practices, both primary and secondary preventive practices, among the elderly. That is a major research area within the medical community now. But I think the short answer is that we don't know how to plan for some of those things at this point.

Senator HEINZ. Doctor, thank you very much for your testimony.

The **CHAIRMAN.** Thank you very much, Doctor, for being with us today.

Dr. **LAVIZZO-MOUREY.** Thank you.

The **CHAIRMAN.** Mr. Ed Howard, Coordinator of Public Policy for Villers Advocacy Associates.

Welcome, Mr. Howard.

STATEMENT OF ED HOWARD, COORDINATOR OF PUBLIC POLICY, VILLERS ADVOCACY ASSOCIATES

Mr. **HOWARD.** Thank you, Mr. Chairman. I will try to be as brief as humanly possible, Mr. Chairman, given the time situation.

I thank you for this chance to testify on what can only be called the startling increases in Part B premiums. We are a nonprofit organization concerned about low- and moderate-income older people, so naturally we're deeply concerned about the implications for both poor and economically vulnerable older people of this Part B premium increase which takes effect next January.

So in my statement I'm going to focus less on the causes of this increase, about which you've heard a great deal today, and focus a little more on the impact that it's going to have on the people that we're concerned about.

Measured either by percentage or dollars, this is by far the largest increase in the Part B premium that beneficiaries have ever experienced or will experience. It certainly isn't the only one; during the first half of 1981 the premium was $9.60 a month. When it goes to $24.80 in January, beneficiaries will have experienced a jump of 158 percent in 7 years, four times as fast as the consumer price index. And because those increases are paid by everyone in exactly the same amount regardless of income, it has a disproportionate impact on people with low and moderate incomes.

There is very little talk these days about poverty among the elderly. Some people have tried to declare it "abolished." We have come a great distance; we've reduced it from a third of the elderly population to just about one in eight, but I've laid out in my testimony some of the factors that are masked by those aggregate figures, including the fact that the number of older people below the official poverty line has actually increased in each of the last couple of years.

But perhaps most striking, and it's something that you picked up in your conversation with Mr. Shulman, is that there are millions more additional older people above the official poverty line but still economically vulnerable. Using a measurement of 200 percent of poverty, which amounted to the grand sum of $202 a week last year, 41 percent of older people—11.5 million of them—fall below that line. We hear an awful lot, as we properly should, about how disgraceful the poverty rate is among children under 18. When you use the 200 percent of poverty measure, it is exactly the same for that group and for people over 65, 41 percent.

Now, some may think that as heavy burden as these out-of-pocket expenses for health care are for low- and moderate-income older people, that Medicaid is somehow going to cover those expenses and make it less burdensome. Well, it will for a few, but, unfortunately, it's more false than true, even for people classed as poor.

First, for a variety of reasons, only about 36 percent of the poor elderly actually participate in Medicaid, just over one in three. More than 2 million people are represented by that statistic

Second, even among people who are fortunate enough to be on Medicaid, Part B premiums may or may not be picked up, depending on the practice of the particular State in which they reside. I've included a chart that shows how State practices differ. Only about 18 States actually pay the premium and the deductible and co-payments for all of their Medicaid dual-eligibles. In fact, about a million elderly Medicaid recipients still pay the Part B premium themselves. I should say that figure includes some people who aren't technically poor; they have to spend down into poverty in order to qualify for Medicaid.

Now, according to news reports, negotiators on the budget have been talking about holding Social Security COLA's to 2 percent below inflation but rejected it as politically untenable. As AARP's statement pointed out, almost three-quarters of a million people with low Social Security benefits would, if this increase goes into effect, have their entire COLA wiped out—minus 100 percent. And figures from that same testimony show that if you add to that increase the $4.00 a month flat premium increase included in the catastrophic health bill just passed by the Senate last week, 4 million more Social Security Medicare beneficiaries would have their entire COLA wiped out by this increase.

Now, over the long run there appears to be general consensus that the most effective way to control Part B premiums is to control Part B costs. That's going to involve substantial overhaul of our physician payment system. The question is, what do we do now? For 11.4 million economically vulnerable who are poor senior citizens, these aren't symptoms of some larger ailment. This is the ailment. Senior groups across the country with whom we are in touch are alarmed about this threatened increase and are asking what can be done. It touches nerves that the catastrophic bill and long-term care and some of the other issues that a lot of us have been spending a lot of time on don't really touch.

I've laid out a few basic possibilities under the category of "what to do because the doctor is coming," and the first one is the most compelling. That is to lower the increase. Let's not accept that the 38.5 percent increase needs to go into effect. It's going to be expensive to fix, but it's going to be expensive for the beneficiaries to pay, almost by definition. Build-up of reserves can be slowed. New revenue can be raised with some nexus to the Medicare program.

Second, whatever we do about that 38 percent increase, we need to protect low-income beneficiaries. Two specific things: First, let's work to hold on to the buy-in that's in the House version of the catastrophic bill. It would allow coverage for Medicare cost-sharing, including the Part B premium, for all Medicare beneficiaries below the poverty line. Second, to come closer—at least on the flat premium side—to the House rather than the Senate version of financing the catastrophic bill.

Third, we need to encourage greater acceptance of assignment. On the average $105 will be paid by each Medicare beneficiary in

1987 because doctors don't accept Medicare's judgment of what's fair as full payment. And while any mandate along these lines should reasonably be accompanied by a more general reform in physician payment, the question is, who bears the burden until we can figure out the rational way to restructure the system?

Last year, when the Part A deductible was scheduled to go up by 17 percent, Senator Heinz and other members of the committee moved very aggressively and swiftly to moderate that increase. That quite properly—even though only a fourth of Medicare beneficiaries actually incurred that deductible cost, and most of them have Medigap coverage that prevents them from having to pay it out-of-pocket. Here you have an increase that every Medicare SMI beneficiary is going to pay. We believe that it deserves the same kind of swift and vigorous action to deal with it.

Some Medicare beneficiaries, unless some action is taken—a substantial number, perhaps—are going to let their Part B coverage lapse because they won't be able to afford the $7 or $11—or somewhere in between—more a month that is going to result from the combination of these factors. We think that's moving in the wrong direction and we urge your immediate attention to try to find a fiscally sound and humane solution to that problem.

[The prepared statement of Mr. Howard follows:]

THE MEDICARE PART B PREMIUM INCREASE: GROWING BURDEN ON ALL BUT THE WELL-OFF ELDERLY AND DISABLED

Testimony by

EDWARD F. HOWARD
Public Policy Coordinator

VILLERS ADVOCACY ASSOCIATES

before the

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

Monday, November 2, 1987
Washington, DC

Mr. Chairman and members of the Committee, thank you for inviting me to testify at this important hearing on the coming increases in the monthly premium for supplemental medical insurance (SMI), or Part B, of Medicare.

Villers Advocacy Associates is a non-profit organization concerned about the impact of public policy decisions on low and moderate-income older people. It follows, therefore, that we are deeply disturbed about the implications for poor and economically vulnerable elders of the recently announced $83 jump -- $6.90 a month -- in the Part B premium, to take effect in January.

Measured by either percentage or dollars, the size of this increase is unprecedented in the 22 years of Medicare's operation. Moreover, this increase comes on top of a number of significant increases in the past several years. During the first half of 1981, the premium was $9.60 a month; in January 1988, when the $24.80 premium takes effect, Medicare beneficiaries will have experienced a jump in premiums of 158% in just seven years -- more than four times as fast as the consumer price index. See Chart 1.

And because these premium increases are uniform for all beneficiaries, regardless of income, they have fallen especially hard on those with low incomes.

There is little discussion these days about poverty among the elderly. Medicare and social security are widely described as "sacred cows" that benefit primarily middle- and upper-income people. Poor elders? It's a stereotype from a generation ago, and, so the new thinking goes, an outmoded one.

It is true that, in general, the incomes of older people have improved substantially since 1960, when more than a third of those over 65 had incomes below the poverty line. Now the proportion is just 12.4% in poverty, a lower rate than for the non-elderly population (13.8%), and far below the rate for children (19.8%). But consider these facts:

- °Poverty among elders remains the highest among any adult age group.
- °The number of elders in poverty, virtually unchanged over the past decade, actually increased in 1985 and 1986 -- the only age group, including children, for which that is true.
- °Older Americans make up only one-eighth of the population, but account for one-third of those labeled "persistently" poor.

Perhaps most striking, millions of elders are "economically vulnerable," that is, have incomes higher than the poverty line, but under twice that figure. An older individual last year was classed as economically vulnerable" if he or she had income of $202 a week or less. There were almost eight million "economically vulnerable" older Americans lastyear. That means 11.4 million elders -- 41% of the total older population -- had incomes below 200% of the poverty line. It is sadly ironic that the "economic vulnerability" rate among children last year was exactly the same -- 41%.

For these "economically vulnerable" and poor Medicare beneficiaries, the increase in the premium will hit hard. That $83 will come on top of the $215 premium already due; the $75 Part B deductible that almost 80% of Medicare beneficiaries will pay, and the $540 hospital deductible that about one fourth will incur.

These high and growing out-of-pocket expenses for health care are widely understood to be a burden for low- and moderate income elders. What is less well understood is that very few of them are actually protected from these costs by Medicaid. Because of restrictive income limits and even more restrictive resource limits, limited outreach and, to some extent, reluctance to participate in a means-tested program, participation in Medicaid by the elderly poor is only about 36%. Even the relatively old data available show that more than two million poor elders are not participating in Medicaid.

Not even all those on Medicaid are protected against this

Part B increase. Although States may pick up the Medicare out-of-pocket cost-sharing, including the premium, for those enrolled, only 18 states "buy in" to Medicare for all eligible Medicaid enrollees. See Table A. In all, almost a million elderly Medicaid recipients must still pay the Part B premium themselves, or not be enrolled themselves. See Table B. In all, more than three million poor elders will have no protection at all against the upcoming increase.

The increase, of course, is a general one, which will cost seniors and disabled persons some $2.6 billion next year. In every state, the personal impact will be felt, as will be the general economic impact. A breakdown of how much the increase will cost beneficiaries in each state is shown in Table C. Also included in the table is the additional cost to beneficiaries of yet another increase in the flat premium approved last week by the Senate. As the Committee well knows, the Senate Catastrophic Protection bill includes an increase of $4 in the flat premium beginning in April 1988. That would mean a 50% increase -- from $17.90 to $28.80 -- within three months.

Testimony by AARP shows that almost three-quarters of a million persons with low social security benefits will have their January 1988 cost-of-living adjustments wiped out by the Part B premium increase. Data from the same testimony show that an additional four million persons would lose their entire COLAs if the increase in S. 1127 is allowed to take effect along with the already-scheduled January increase. Additional millions would have their COLAs reduced substantially.

The Committee has heard a great deal of testimony, including several witnesses today, about the underlying causes of these increases. There appears to be a general consensus that, over the long run, the most effective way to control Part B premiums is to control Part B costs. that will involve substantial overhaul of our physician payment system. But for the 11.4 million poor and economically vulnerable elders in America, the premium increases looming in January (and April, under the Senate version of Catastrophic) are not a symptom of some larger ailment; they are, rather, life-threatening ailments in their own right. We urge you, Mr. Chairman, and the other members of the Committee, to take the leadership in attempting to deal with the impact of these increases -- not eventually, as part of some larger, more rational reform effort, but immediately and decisively, to protect those who will otherwise be at risk.

Here are a few possible actions:

1. Legislate lower increase. We understand that canceling this 38% increase, or even restraining it substantially, will be expensive. That is true whether the expense is borne by the Federal Government or, as current law would have it, by the beneficiaries. Revenue can be raised from sources with a logical connection to the Medicare program.

2. Protect low-income beneficiaries. Two specific steps could be taken that would ease the burden on the most vulnerable elders. Both involve the catastrophic health bill now awaiting conference. First, the so-called "buy-in" in the House bill, under which the Medicaid program would cover Medicare cost-sharing (including the Part B premium) for poor beneficiaries, should be retained. Second, the flat premium increase contained in the Senate version should be minimized or eliminated. That would protect those who would not qualify for the buy-in, but for whom the additional flat premium increase would be a real hardship.

3. Encourage/require assignment. On average, each Medicare beneficiary will pay $105 this year in "balance billing" -- usually, bills from physicians for amounts in excess of what Medicare has determined to be fair. Movement twoard restoring Medicare's promise that it would pay 80% of medical bills would ease the burden on many beneficiaries. Again, while any mandate along these lines would, more reasonably, be accompanied by a general payment reform scheme, why should beneficiaries bear the interim burden alone?

Mr. Chairman and members of the Committee, you have been in the forefront this year of attempting to extend protection to all seniors against the risk of devastating, catastrophic health care costs. The $83 -- or, perhaps, $119 -- premium increase facing seniors in 1988 will, for millions of them, translate into quiet but relentless devastation. This hearing itself is evidence of your commitment to trying to avoid that impact, and we are very grateful for it. We look forward to working with you toward a humane and fiscally sound solution. Thank you.

CHART 1

INCREASES IN MONTHLY SMI PREMIUM

AND CONSUMER PRICES, 1975-88

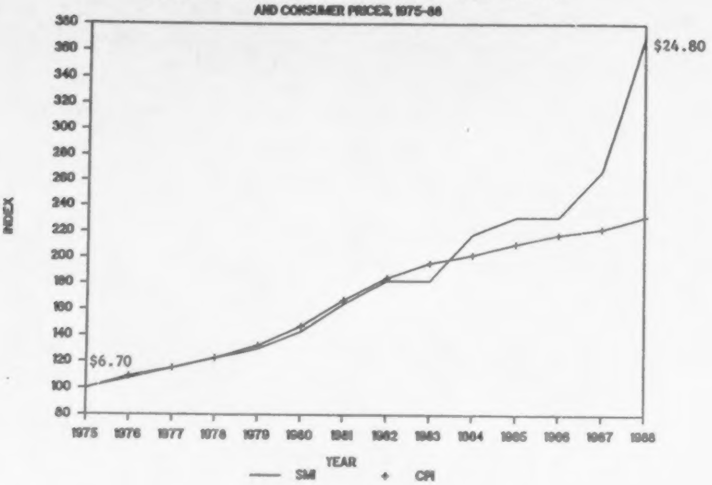


Table A

STATE "BUY-IN" AGREEMENTS

States Which Buy-in For Only Cash Assistance Recipients

Connecticut
Delaware
Illinois
Kentucky
Louisiana
Maine
Massachusetts
Minnesota
Missouri
Nebraska
New Hampshire
New York
North Dakota
Oklahoma
Pennsylvania
Rhode Island
South Dakota
Tennesse
Vermont
West Virginia
Wisconsin

States Which Buy-in For Cash and Non-Cash Recipients, but Have No Medically Needy Program

Alabama
Alaska
Colorado
Florida
Idaho
Indiana
Mississippi
Nevada
New Jersey
New Mexico
Ohio

States Which Buy-in for Cash and Non-Cash Recipients, including the Medically Needy

Arizona
Arkansas
California
District of Columbia
Georgia
Hawaii
Iowa
Kansas
Maryland
Michigan
Montana
North Carolina
Oregon
South Carolina
Texas
Utah
Virginia
Washington

States with No Buy-in Agreements

Wyoming

Source: Lyons, Barbara, School of Hygiene and Public Health, Johns Hopkins Univ., Unpublished paper, October 1987.

TABLE B
Number of Elderly Poor Unprotected Against Proposed Medicare Part B Premium Increases
(in thousands)

STATE	ELDERLY MEDICAID RECIPIENTS WITHOUT MEDICARE PART B COVERAGE	ELDERLY WITH SUB-POVERTY LINE INCOMES W/O MEDICAID COVERAGE	TOTAL
Alabama	0.0	73.0	73.0
Alaska	1.8	0.9	2.7
Arizona	0.0	22.3	22.3
Arkansas	0.0	50.9	50.9
California	73.8	115.0	188.8
Colorado	3.8	18.1	21.9
Connecticut	20.1	18.2	38.3
Delaware	0.3	4.6	4.9
D.C.	0.3	8.2	8.5
Florida	0.0	127.7	127.7
Georgia	0.0	76.6	76.6
Hawaii	3.1	4.7	7.8
Idaho	1.1	8.7	9.8
Illinois	39.8	86.0	125.8
Indiana	3.4	42.5	45.9
Iowa	4.5	28.7	33.2
Kansas	0.0	24.6	24.6
Kentucky	18.2	55.3	73.5
Louisiana	106.2	64.8	171.0
Maine	12.7	13.2	25.9
Maryland	1.2	28.9	30.1
Massachusetts	130.1	39.8	169.9
Michigan	37.9	63.9	101.8
Minnesota	42.5	39.4	81.9
Mississippi	7.3	58.0	65.3
Missouri	26.3	65.0	91.3
Montana	0.9	7.0	7.9
Nebraska	10.0	17.9	27.9
Nevada	0.9	4.1	5.0
New Hampshire	7.1	7.3	14.4
New Jersey	4.9	49.5	54.4
New Mexico	0.0	14.5	14.5
New York	143.0	143.8	286.8
North Carolina	18.3	83.7	102.0
North Dakota	4.1	7.6	11.7
Ohio	11.6	85.0	96.6
Oklahoma	15.6	45.4	61.0
Oregon	19.6	20.7	40.3
Pennsylvania	33.7	105.5	139.2
Rhode Island	23.5	9.3	32.8
South Carolina	2.1	42.5	44.6
South Dakota	3.4	10.2	13.6
Tennessee	6.8	75.6	82.4
Texas	20.7	166.0	186.7
Utah	3.7	7.6	11.3
Vermont	3.8	4.6	8.4
Virginia	8.8	50.4	59.2
Washington	5.0	28.0	33.0
West Virginia	5.9	26.1	32.0
Wisconsin	39.0	30.4	69.4

Table C

COST TO MEDICARE BENEFICIARIES OF PART B PREMIUM INCREASES, BY STATE

	Aged Beneficiaries	Disabled Beneficiaries	Total Beneficiaries	Increased Part B Premium Costs for 1988	Proposed Increased Current Law Part B Premium Increase Plus Increase in S.1127, 1988
NEW ENGLAND					
MAINE	150,940	14,875	165,815	$13,762,645	$19,731,985
NEW HAMPSHIRE	112,347	8,686	121,027	$10,045,241	$14,402,213
VERMONT	61,788	6,007	67,795	$5,626,985	$8,067,605
MASSACHUSETTS	740,119	56,927	797,046	$66,154,818	$94,848,474
RHODE ISLAND	132,[illegible]88	12,310	144,898	$12,026,534	$17,242,862
CONNECTICUT	398,108	27,988	426,096	$35,365,968	$50,705,424
MIDDLE ATLANTIC					
NEW YORK	2,154,664	206,241	2,360,905	$195,955,115	$280,947,695
NEW JERSEY	923,973	82,475	1,006,448	$83,535,184	$119,767,312
PENNSYLVANIA	1,632,307	147,073	1,779,380	$147,[illegible]88,540	$211,746,220
EAST NORTH CENTRAL					
OHIO	1,246,437	126,303	1,372,740	$113,937,420	$163,356,060
INDIANA	619,595	60,854	680,449	$56,477,267	$80,973,431
ILLINOIS	1,299,870	106,764	1,406,634	$116,750,622	$167,389,446
MICHIGAN	995,467	112,393	1,107,860	$91,952,380	$131,835,340
WISCONSIN	603,309	49,175	652,484	$54,156,172	$77,645,596
WEST NORTH CENTRAL					
MINNESOTA	505,362	32,760	538,122	$44,664,126	$64,036,518
IOWA	400,500	27,872	428,372	$35,554,876	$50,976,268
MISSOURI	655,884	63,087	718,971	$59,674,593	$85,557,549
NORTH DAKOTA	85,376	5,538	90,914	$7,545,862	$10,818,766
SOUTH DAKOTA	94,790	6,443	101,233	$8,402,339	$12,046,727
NEBRASKA	209,669	12,909	222,578	$18,473,974	$26,486,782
KANSAS	314,746	20,810	335,556	$27,851,148	$39,931,164
SOUTH ATLANTIC					
DELAWARE	67,639	6,992	74,631	$6,194,373	$8,881,089
MARYLAND	424,028	38,959	462,987	$38,427,921	$55,095,453
D.C.	66,531	6,429	72,960	$6,055,680	$8,682,240
VIRGINIA	547,695	65,640	613,335	$50,906,805	$72,986,865
WEST VIRGINIA	244,440	38,702	283,142	$23,500,786	$33,693,898
NORTH CAROLINA	670,108	85,810	755,918	$62,741,194	$89,954,242
SOUTH CAROLINA	320,360	48,631	368,991	$30,626,253	$43,909,929
GEORGIA	554,779	82,164	636,943	$52,866,269	$75,796,217
FLORIDA	1,829,339	135,740	1,965,079	$163,101,557	$233,844,401
EAST SOUTH CENTRAL					
KENTUCKY	421,043	60,534	481,577	$39,970,891	$57,307,663
TENNESSEE	543,800	71,112	614,912	$51,037,696	$73,174,528
ALABAMA	457,017	61,784	518,801	$43,060,483	$61,737,319
MISSISSIPPI	289,896	44,146	334,042	$27,725,486	$39,750,998
WEST SOUTH CENTRAL					
ARKANSAS	317,962	40,024	357,986	$29,712,838	$42,600,334
LOUISIANA	397,262	56,006	453,268	$37,621,244	$53,938,892
OKLAHOMA	375,764	32,452	408,216	$33,881,928	$48,577,704
TEXAS	1,438,210	122,744	1,560,954	$129,559,182	$185,753,526
MOUNTAIN					
MONTANA	94,602	8,383	102,985	$8,547,755	$12,255,215
IDAHO	105,948	8,185	114,133	$9,473,039	$13,581,827
WYOMING	40,848	2,680	43,528	$3,612,824	$5,179,832
COLORADO	270,858	23,348	294,206	$24,419,098	$35,010,514
NEW MEXICO	130,734	14,182	144,916	$12,028,028	$17,245,004
ARIZONA	361,809	32,955	394,764	$32,765,412	$46,976,916
UTAH	122,503	8,410	130,913	$10,865,779	$15,578,647

The CHAIRMAN. I am rather intrigued, Mr. Howard, with your recommendation. In your first recommendation for possible action you say that if we either cancelled or restrained part of the increase, that revenue could be raised from sources with a logical connection to the Medicare Program. I think that if we could agree here in Congress on where the offsetting revenue would come from I believe we'd do the right thing and hold down this $6.90 Part B increase.

What revenue are you talking about?

Mr. HOWARD. Well, I wish I had some innovative and creative new source of revenue, Mr. Chairman. The ones I'm going to tick off you've heard before, but they do fit the definition in the statement. Most of them have been mentioned this morning.

First of all, workers who are not now participating in Medicare because of their status as State and local employees—90 percent of those people are going to get coverage eventually anyway. For them, it's a windfall. The other 10 percent need it and for them it's a good deal, and they ought to be paying it, too.

We've heard some talk about restraining the size of increases in physician fees. While that is indeed not the most rational way to design a physician payment program, is it less rational than requiring 11.4 million economically vulnerable older people to pay 38 percent more?

A number of people have suggested some sort of increase in tobacco taxes, about which I suspect you wouldn't get unanimous consent in the Senate, but there certainly is a connection between the diseases and illnesses caused by tobacco use and Medicare expenditures.

Finally, we've talked about building up the reserves that are in the Part B trust fund more slowly than the administration has proposed, with the $1.50 attributed to that particular purpose.

I think with a little creativity and a little advocacy we could put together a package with those and some other factors that could be a reasonable alternative to letting this go forward.

The CHAIRMAN. If the two steps were taken that you recommended in regard to the catastrophic legislation, what do you think we're talking about in protecting the 11 million older Americans that might be placed in jeopardy because of this Part B increase?

Mr. HOWARD. Well, if a way could be found to avoid the $4 flat increase, or at least to minimize it, every one of them—except those already on Medicaid and having it paid for them—would benefit, as would a number of States that do buy in for their dual beneficiaries now that are going to have to pay that increased flat premium.

That would be a very substantial help. They would still be saddled with the $7 increase, but that would be better than the $11.

As for the buy-in, it would help a number of people with incomes below the poverty line, that 3.5 million with incomes below the poverty line. Some are not going to participate because they won't know about it, or because they have assets over $1,800 or $1,900 that would disqualify them for coverage, or because they think that this is somehow welfare and don't want to take advantage of it. But we could reach a good part of 1 million people that way.

The CHAIRMAN. All right. Thank you very much.

Senator Heinz.

Senator **Heinz**. No questions, Mr. Chairman.

The **Chairman**. Thank you very much, Mr. Howard, for your testimony.

Mr. **Howard**. Thank you, Mr. Chairman.

The **Chairman**. Doctor P. John Seward, Chairman, American Medical Association Council on Legislation.

Doctor Seward.

STATEMENT OF P. JOHN SEWARD, M.D., CHAIRMAN, AMERICAN MEDICAL ASSOCIATION COUNCIL ON LEGISLATION, ACCOMPANIED BY BRUCE BLEHART, DIRECTOR, DEPARTMENT OF FEDERAL LEGISLATION, AMA

Dr. **Seward**. Thank you, Mr. Chairman, members of the committee. My name is John Seward; I am a family practitioner from Rockford, Illinois. I am also chairman of the Council on Legislation for the American Medical Association. With me is Bruce Blehart of the Association's Department of Federal Legislation.

We certainly appreciate this opportunity to appear before this committee to discuss the announced Medicare Part B premium increases for 1988.

The AMA is disappointed in the projected need to increase the Part B premium by 38.5 percent. While the issue that seems to have flagged the major concern is the 38.5 percent increase projected for the Part B premium in 1988, the formula for determining the Part B premium is set by statute. As you have already been informed, a significant portion of the premium increase reflects the administration's need to build up trust fund reserves depleted by its previous decision to spend down reserves.

The AMA agrees that this increase and its potential effects on beneficiaries deserve close consideration. However, the real issue that needs to be addressed is the total of expenditures for physician and other Part B services under Medicare.

We have been told by Medicare that the projected level of spending for Part B services for the period of July 1986 to June 30, 1987 represents an 18.8 percent increase over the expenditures of the previous 12-month period. Mr. Chairman, this level of increase should not have been unexpected or seen as unrealistic. An 18.8 percent increase in Part B expenditures is not inconsistent with historic patterns of Part B program growth. On average, the program has grown by 17.2 percent annually over the past 10 years and has experienced an annual growth over 18 percent in 10 of the past 14 years.

It is appropriate, though, to dissect the approximately 20 percent increase in Part B expenditures and make efforts to isolate and correct any elements that have inappropriately caused program expenditures. According to HCFA, when the increases accounted for by enrollment growth and reasonable charges are factored out, a residual increase of approximately 9.05 percent remains due to utilization/intensity.

Mr. Chairman, most of this increase is attributable directly to Medicare beneficiaries receiving necessary and valuable services for their well-being. Furthermore, this level of expenditures can be traced to a myriad of factors, including: The growth and aging of the Medicare population; the deductible being maintained at the level set in 1981; assignment being more readily accepted; charges having been held down; and costs declining in relationship to price.

It is also our experience that utilization/intensity under Part B is increasing for the Medicare population. As acknowledged by HCFA, this element has averaged a 6.2 percent increase over the past 10 years and a 6.7 percent increase over the last 5 years. An increase of 2.35 percent on top of that 6.7 percent should be evaluated in light of increased benefits under Part B and pressures on physicians to provide a greater share of the care that Medicare beneficiaries receive.

In addition, more beneficiaries are availing themselves of Part B services. The portion of beneficiaries receiving reimbursed physician services increased from 67 percent to 76 percent between 1981 and 1986. Shorter hospital lengths of stay and increased use of nonhospital sites for care have resulted in a more intensive physician service being provided.

It is reasonable that Part B expenditures will reflect an accelerating increase in utilization/intensity.

Mr. Chairman, we have seen no evidence to indicate that the increase in utilization/intensity was inappropriately caused by physicians. In our full statement we discuss the draft report prepared for the HHS Assistant Secretary for Planning and Evaluation that finds increases in intensity do not reflect fraudulent or improper changes in billing practices. If there were improper changes, the AMA would be at the forefront of efforts to address such a problem.

Mr. Chairman, the increases in the use of physician services represent expanded access to care that the Medicare Program holds out to the elderly, that public policies have reinforced, that beneficiaries have come to expect, and that physicians continue to provide. The increase in program expenditures illustrates that improvements in beneficiary access are not without cost.

In conclusion, physicians have received unjustified bad publicity over the projected increase in the Part B premium. Physicians have taken part in a voluntary fee freeze, have been subjected to congressionally imposed reimbursement and fee freezes, and are now subject to the MAAC price control. No other sector of the economy and no other Government program has so many price controls.

Mr. Chairman, the AMA will be pleased to work with you and the committee in seeing that Medicare beneficiaries continue to receive quality health and medical care services and that public dollars are spent wisely. We will be pleased to respond to any questions from the committee, Mr. Chairman.

[The prepared statement of Dr. Seward follows:]

STATEMENT

of the

AMERICAN MEDICAL ASSOCIATION

to the

Special Committee on Aging
United States Senate

Presented by

P. John Seward, M.D.

RE: Medicare Part B Premium for 1988

November 2, 1987

Mr. Chairman and Members of the Committee:

My name is P. John Seward, M.D., and I am a family practitioner from Rockford, Illinois. I am also the Chairman of the Council on Legislation of the American Medical Association. With me is Bruce Blehart of the Association's Department of Federal Legislation.

The AMA appreciates this opportunity to appear before the Committee to discuss the announced Medicare Part B premium increase for 1988. We are disappointed in the the projected need to increase the Part B premium by 38.5%, and we hope information—not heretofore available—will be forthcoming at this hearing so that specific causes for the increase can be identified and analyzed. The AMA agrees that this large increase and its potential effects on beneficiaries deserve close consideration. The real issue is the level of total expenditures for physician and other Part B services under Medicare.

Mr. Chairman, physicians have taken part in a voluntary fee freeze, been subjected to Congressionally-imposed reimbursement and fee freezes, and then subjected to the currently imposed price controls known as MAACs. No other sector of the economy and no other government program has so many price controls.

It is also important to point out that a substantial percentage of the projected premium increase is directly attributable to lack of an increase in the premium in 1986 and the fact that the Administration last year decided not to impose the full 1987 premium increase by spending down trust fund assets. In 1987, the premium was increased to $17.90 instead of $19.30. If the full 1987 premium increase had been imposed, that premium would have represented a 21% increase, and the potential 1988 premium of $24.80 would represent a 28% increase.

It is the experience of physicians across the country that shorter hospital stays and increased use of non-hospital sites for care frequently have resulted in a more intensive physician service being provided. By way of example, a hospitalized patient who (previous to the PPS) may have been in the hospital for a seven-day period and who today is discharged on the fourth day following surgery will utilize more Part B covered ancillary services and require more intensive physician involvement. While the hospital and personnel who routinely would have provided patient care in the hospital (Part A) will be relieved of responsibility on discharge, the fact that patient care is still needed does not disappear.

With physicians strongly discouraged from admitting patients, and especially with the increasing age of the Medicare population and the rapid growth of ambulatory surgery, it is reasonable that Part B expenditures will reflect an increase in utilization/intensity. We need to examine carefully the extent to which savings accruing to the Part A side of Medicare may offset expenses added to the Part B side.

When the freeze on physician reimbursement was incorporated into the Deficit Reduction Act of 1984, the Congress called for a study to analyze whether physician "gaming" would take place. Preliminary results of a similar study being completed by Peter D. McMenamin, Ph.D., for the HHS Assistant Secretary for Planning and Evaluation, point out that physicians have been scrupulous in their dealings with the Medicare program. The draft report indicates that the increase in intensity does not reflect fraudulent or improper changes in billing practices. Dr. McMenamin also examined the issue of visit "unbundling" and concludes that there was no volume response with respect to follow-up visits.

To date, we have seen no evidence to indicate that the increase in utilization/intensity was inappropriately "caused" by physicians. If there were, the AMA would be at the forefront of efforts to address such a problem.

To the contrary, Dr. McMenamin's analysis points out a number of plausible factors, including:

- The growth and aging of the Medicare population;
- Maintaining the deductible at the level set in 1981;
- Assignment being more readily accepted;
- Charges having been held down; and
- Costs of office visits declining in relative price.

Dr. McMenamin aptly points out that any volume increase would not be inconsistent with a demand response on the part of beneficiaries.

An additional factor not mentioned in this study that directly relates to the relative price of physician services is that approximately 70% of the Medicare population are covered by private medigap policies that effectively provide first dollar coverage on deductible and coinsurance. Increased utilization by beneficiaries as a result of lower real out-of-pocket costs is not to be unexpected. The recently completed Rand Health Insurance Experiment has found that a reduction in beneficiary cost-sharing for services leads to an increase in the volume of services used.

Mr. Chairman, the increase in the use of physician services represents expanded access to care that the Medicare program holds out to the elderly, that public policies have reinforced, that the beneficiaries have come to expect, and that physicians continue to provide. In fact, physicians have provided this expanded level of care with virtually no increase in program reimbursement between 1983 and 1986. However, the increase in program expenditures illustrates that improvements in beneficiary access are not without cost.

Medicare Part B Expenditures

We have been told by Medicare that the projected level of spending for Part B services for the period of July 1, 1986 to June 30, 1987 represents a 19.9% increase in expenditures over the previous 12-month period, and that this increase would have been 18.8% absent the required standard on faster claims processing. This level of expenditure increase should not be unexpected or seen as unrealistic. An 18.8% increase in Part B expenditures is not inconsistent with the historic pattern of Part B program growth. On average, the program has grown by 17.2% annually over the past ten years and has experienced an annual growth of over 18% in ten of the past fourteen years.

Without question, the growth in the Part B program over the years represents increased access to effective and sophisticated health care services for our nation's elderly and disabled.

Analysis of Part B Expenditures

It is appropriate to dissect the approximately 20% increase in Part B expenditures and make efforts to isolate and correct any elements that have inappropriately caused program expenditures. The Health Care Financing Administration (HCFA) has issued the following facts:

> "During the twelve-month period, July 86-June 87, carriers paid a total of $22.1 billion in benefits, an increase of 19.9% over the same twelve-month period in the prior year....

> Data for the most recent six-month period indicate that the rate of increase in payments appears to be accelerating, with benefits increasing by 22.4%.... However, both the twelve-month and six-month rate of increase probably overstate the underlying trend since claims processing has accelerated. A rough estimate of the real increase, net of the effect of faster claims processing(,) is 18.8% for the July 86-June 87 increase and 16.6% for the most recent six-month period. [NOTE: FOR THE TWELVE-MONTH PERIOD, 5.5% OF THE INCREASE IS DUE TO CLAIMS PROCESSING ACCELERATION, AND DURING THE PAST SIX-MONTH PERIOD VIRTUALLY 26% OF THE INCREASE IS DUE TO THIS FACTOR.]
>
> Taking the adjusted 18.8% increase experience during the most recent twelve-month period, the contribution of price, beneficiary population and utilization, (are) as follows:
>
> o reasonable charges increased to 6.8%.
>
> o enrollment increased 2%.
>
> When the increases accounted for by enrollment and growth and reasonable charges are factored out, a residual increase of approximately 9.05% (emphasis added) remains due to utilization/intensity and this 9.05% increase is considerably higher than what we have experienced in recent periods.
> Utilization/intensity has averaged 6.2% per year for the last ten years, (and) 6.7% for the last five years.

Prior to focusing on the element labeled as "utilization/intensity," I feel it important to point out that the 6.8% attributable to "charge increases" came about due to justifiable Congressional action that allowed increases in prevailing charge levels for the first time since July 1, 1983. Most of this level of increase was given to physicians who entered into agreements with the government to accept all of their Medicare claims on an assigned basis. Non-participating physicians saw their first increase in Medicare payments on January 1, 1987.

Mr. Chairman, I cannot believe that the limited amount of increase allowed for prevailing charge payments can be at issue based on the fact that Medicare has historically under-reimbursed for the services provided.

Utilization/Intensity

The residual from the specific factors mentioned above arbitrarily has been labeled as "utilization/intensity," with the inference being that this amount is simply too much. Mr. Chairman, most of this increase is attributable directly to Medicare beneficiaries receiving necessary and valuable services for their well being. Furthermore, this level of expenditures can be traced to a myriad of factors. We have requested the Health Care Financing Administration to break out specifically what has been purchased with the Part B dollars. To date we have received no formal response to the specific questions raised in our inquiry. (A copy of our letter to HCFA is attached.)

First of all, an expenditure increase is by no means wholly inappropriate. It is our experience that utilization/intensity under Part B is increasing for the Medicare population. As stated by HCFA, this element has averaged a 6.2% increase over the past ten years and a 6.7% increase over the last five years. An increase of 2.35% on top of the average increase figure of 6.7% needs to be evaluated in light of increased benefits under Part B and on pressures on physicians to provide a greater share of the care that Medicare beneficiaries receive. In addition, the fact that more beneficiaries are availing themselves of Part B services must be considered. The Medicare actuaries, for example, estimate nationally that the proportion of beneficiaries receiving reimbursed physician services increased from 67% to 76% between 1981 and 1986. This fact alone accounts for a significant increase in Part B expenditures.

Conclusion

In conclusion, physicians have received unjustified bad publicity over the projected increase in the Part B premium. This Committee is to be commended for this hearing aimed at identifying facts for the public. Unfortunately, the same public that has been told that physicians are the root cause of the problem is unlikely ever to be presented with a clear statement of the facts as to what has caused the growing expenses of Part B of Medicare. Such misinformation has the doubly unfortunate aspect of breeding mistrust between patients and their physicians.

Mr. Chairman, the AMA will be pleased to work with you and the Committee in seeing that Medicare beneficiaries continue to receive quality health and medical care services and that public dollars are spent wisely. Whether public expenditures are for the purchase of defense equipment, food or housing under welfare programs, or medical services under Medicare, the public has the right to expect accountability. Such accountability necessitates the availability of all of the facts, and we will also work with the Administration when that information, as we requested, is available from HCFA.

We will be pleased to respond to any questions from the Committee.

AMERICAN MEDICAL ASSOCIATION
535 NORTH DEARBORN STREET • CHICAGO, ILLINOIS 60610 • PHONE (312) 645-5000 • TWX 910-221-0300

JAMES H. SAMMONS, M.D.
Executive Vice President
(645-4300)

September 18, 1987

William L. Roper, M.D.
Administrator
Health Care Financing Administration
Department of Health and Human Services
200 Independence Ave. S.W.
Washington, D.C. 20201

Dear Dr. Roper:

First, let me again express my appreciation for the opportunity to meet with you to discuss the increase in Part B expenditures. The on-going dialogue between our organizations is essential in adequately addressing the underlying causes necessitating the proposed premium increase and responding to the high level of Congressional and media interest in this issue. Unfortunately, some critics, in a rush to judgment, have unfairly laid the blame on physicians for the increase in total Part B expenditures without any documentation of the root causes. Congress and the Administration must determine the underlying factors which explain the increase in Part B spending before even beginning to entertain legislative or regulatory options.

As you know, the Health Subcommittee of the House Ways and Means Committee chaired by Representative Stark will be holding a hearing on September 30 to look into this matter. The AMA has been invited by Chairman Stark to testify at this hearing and we intend to participate. In order for us to develop our testimony, it will be helpful for us to obtain information that is available only from the Health Care Financing Administration.

This letter is to request your immediate assistance in obtaining answers to the following questions so that we will be able to address these important issues:

1. It has been reported that Glen Hackbarth indicated that one reason for the 38% increase in premiums related to a decision by the administration to "spend down some of the contingency reserve." (New York Times, September 15, 1987) What portion of the 38% increase in the proposed premium can be attributed to the catch-up necessary because of the trust fund spend-down? How was it that the premium could be held down in light of the statutory requirement for the Part B premium to cover 25% of program costs?

2. What portion of any increase can be attributed to shifts in services from Part A to Part B? Specifically, can any of the increase be attributed to services that are now provided on an outpatient basis that would previously have been provided under Part A, such as services attributable to increased use of improved outpatient technology, incentives for outpatient surgery, reduced lengths of stays due to DRG implementation, and utilization controls such as preadmission reviews that have shifted procedures to the outpatient setting? Can any of the increase be attributed to outpatient work-ups prior to hospitalization? Ancillary service costs? Technical components?

3. What percentage of the increases can be attributed to general inflation? Increased patient population? Increased number of eligibles filing claims? Increased intensity due to shorter hospital lengths of stay? Increased intensity due to the growth of the over age 75 population.

4. Could you identify the increases by practitioner classification and other service components? For example, how much of the increase is attributed to "physicians" under Section 1861 (r)(1) (M.D. and D.O.) and each of the other practitioners identified in 1861 (r) (podiatrists, chiropractors, optometrists, and dentists)? What portion of the increase is attributable to non-physicians services such as durable medical equipment and other part B services (including home health services provided by a home health agency, rural health clinic services, etc.)?

5. Press reports have also indicated that a significant portion of the increase can be attributed to "increases in fees." Previous to the period in question, Medicare reimbursement was strictly controlled through freezes on prevailing and customary charges and limits on updates in the MEI. Also, fees of non-participating physicians were frozen at the April - June, 1984 levels. Physician reimbursement and fees are still rigorously controlled. Is it your view that the larger-than-expected increases are caused by physician fee increases? If so, we would be interested in knowing to what extent and the specific fee increases that have caused the reported increase?

6. Is there any impact caused by the prompt payment provisions? If so, what percentage relates to increased costs due to prompt payment and what percentage relates to interest paid on overdue claims?

7. Are administrative costs factored into this increase? If so, what percentage of the increase can be attributed to carrier costs, including increased carrier responsibilities, the participating physician program, providing directories of participating physicians, processing of MAAC information and surveillance and monitoring of the MAAC program?

8. The press has indicated that part of the increase relates to increased utilization of services by Part B beneficiaries. Is the Department aware of specific instances of inappropriate utilization patterns or upcoding under Part B?

9. In that controls on physician fees have held down the costs of these services to levels lower than they would have been without the fee controls, how much increased utilization can be attributed to increased demand induced by lower real costs?

10. At the time of implementation, it was projected that implementation of the HMO/CMP option could actually cost the program more money. Can any of this increase be attributed to increased use of the Medicare HMO/CMP option?

11. What percentage of the increase can be attributed to charges submitted by participating physicians? Non-participating physicians?

12. What percentage of the increase can be attributed to increased reimbursement levels to participating physicians?

13. Can any of the increase be attributed to the availability of new or expanded benefits such as the expanded coverage for vision care?

14. Can any of the increase be attributed to payments made during the period in question that were, for whatever reason, deferred from an earlier period?

15. What portion of the increase can be attributable to services provided in hospital outpatient departments? Ambulatory surgical centers?

I recognize that these are complex questions requiring detailed answers. Such information will enable us to address more fully the issues surrounding the announced increases.

I look forward to your prompt reply to this request. In light of the short time available to us, please feel free to have your staff contact our Washington office with the information as soon as any of the information is available.

Sincerely,

James H Sammons, M.D.

James H. Sammons, M.D.

JHS/dl

The **Chairman.** Dr. Seward, of the options that are available and that have been discussed throughout this hearing to control Part B expenditures, which options would the AMA like to pursue?

Dr. **Seward.** Senator, I wish I had an absolute crystal ball that could tell you exactly which one of those is going to work. First of all, I don't think there's going to be a quick fix.

It comes down to hard economic facts, and you've already stated them very well. When you look at this there are basically two different ways you can look at it. You can either decrease benefits or decrease payments for those benefits, and/or a combination of both of those. Those are exceedingly hard decisions. I think they need to be looked at extremely closely, as this committee is doing.

I fear, though, that a very simple quick fix—as the doctors previous to me have testified—in the long run potentially could have more drastic effects. In the future, this committee may even look at what I call the total concept of how the whole Medicare program is structured, Senator. I think you already alluded to the need for this when you dismissed the billing forms. I know that as a family physician when I look at that billing form I can't understand it, either. I think we need to look at the whole Medicare system because as time goes on, there possibly are fatal flaws in that whole system that need to be addressed.

The **Chairman.** Does capitation solve part of the billing form problems?

Dr. **Seward.** It certainly can, Senator. I heard you mentioned that that might have troubles with capitation in Forsyth, Montana. I happen to know where Forsyth is because I married a Montana girl. I think certain capitation programs in other parts of the country besides Forsyth, Montana have potential problems.

The **Chairman.** Well, Doctor, first of all, congratulations on your wise choice of your spouse.

Dr. **Seward.** You're right.

The **Chairman.** Second, would capitation work where you practice?

Dr. **Seward.** We have certain capitation programs now, Senator, such as closed panel-type HMO's, and we had one in my area that did contract with Medicare. There was one problem with that program. It was up and running for approximately a year, and at the end of that time they told all the Medicare patients they were not going to continue with the program. Now these patients are out looking for other services. This distresses me. This is not unusual either, Senator.

The **Chairman.** I am not thinking that there's any one solution to all this, but I'm willing to say that capitation in certain areas and certain conditions is a very fine recommendation by HCFA as a possible solution. I just don't want them to get carried away with that as being the solution and forget about Forsyth, Montana and all the rest of the areas throughout the country that would be left out in the cold if that were the only solution.

What about bundling of services? I understand bundling to mean that a certain package of services whatever they might be, for a specific diagnosis will be paid a pre-determined amount. Is that correct?

Dr. **Seward.** That's how I think I understand it too, Senator.

The CHAIRMAN. In effect it would be patterned after DRG's and the Prospective Payment System for hospitals? Is this part of the answer?

Dr. SEWARD. I think in certain instances that potentially is an answer. You have a problem, though, when you try to come up with a bundle. For instance, on purely an ambulatory basis certain tests all would have to be included in the bundle when a patient comes in. First of all, many times those tests should not have been ordered, as they may not be appropriate for that type of care.

I think in certain procedures and visits there can be certain bundling, like with colonoscopies or endoscopies or other certain types of procedures. But, I think setting up specific standards—that say that every individual when they come in has to have that certain bundle of tests—I find that inappropriate.

One of the problems that needs to be pointed out, Senator, when it comes to bundling, is that doctors were prescribed by law with the fee freeze that came in that we could not unbundle. Frankly, I think that unbundling isn't appropriate. To the extent unbundling is occurring, I'm not sure what the figures are, and this is one of the things we've been trying to assess from HCFA. Also, there are new procedures now that are being performed, for instance, in the office that were never performed there before. These are, I think, part of that concept of "what was unbundled." It wasn't there before. Exactly what percentage of this is involved we would love to know, also.

The CHAIRMAN. Doctor, you've looked at the billing form and you really don't understand it. Is that correct?

Dr. SEWARD. Yes, sir.

The CHAIRMAN. How long have you practiced, Doctor?

Dr. SEWARD. I started my practice when Medicare started, Senator.

The CHAIRMAN. That's a long time. That's 22 years.

How did we ever get in a position where the physician doesn't understand the billing procedure?

Dr. SEWARD. I don't know the answer to that. I wish I did.

The CHAIRMAN. Is it more complicated than for those patients submitting forms from other insurers?

Dr. SEWARD. Yes, sir. It is in my practice, certainly.

The CHAIRMAN. I'm assuming—I think it's a fair assumption—that the insurance company forms that you are filling out in your practice are just the same as somebody that's practicing in downtown Washington, D.C. or in New York or anywhere else in the country. Isn't that true?

Dr. SEWARD. I would think so, sir, yes.

The CHAIRMAN. Earlier, Doctor Roper said in response to my question about who is responsible for the development of the very confusing and complicated paperwork surrounding Medicare claims; he said carriers. However, insurance companies' billing forms are not as complicated as those for Medicare?

Dr. SEWARD. Overall, I think I could probably say that, yes, sir.

The CHAIRMAN. Well, that has to be part of the problem. Generally speaking, I think, that if the people who are in the practice of medicine don't understand what the billing system is, there might be a tendency to protect one's self against the system, and to make sure that there are plenty of charges in there. That would be unethical, wouldn't it?

Dr. SEWARD. Yes, it would.

The CHAIRMAN. But would it happen?

Dr. SEWARD. I am sure there are cases out there, Senator, where this has happened.

The CHAIRMAN. I'm sure there are, too. I regret that very much.

Dr. SEWARD. I do, too.

The CHAIRMAN. I think part of the responsibility for those billing forms rests right here in Congress. I think that we contribute to that immeasurably by the piecemeal actions that we are forced to take in dealing with health care costs. I don't think we're going to get anywhere unless we just attack it relentlessly, day after day, week after week, month after month. I agree with you, Doctor, that there's no one answer. But I think we have to be after it, and I think we have to be after it jointly, including you who are out there practicing and the people in HCFA and in Congress, because we're all serving one group. We're just serving your patients, after all. It's the older Americans that live in this country; we're all trying to help them.

I want to thank you very much. I hope that the AMA will continue to be very interested in this subject.

Is there another group within the AMA, besides the Legislative Council that has been looking at this issue who might testify?

Dr. SEWARD. Yes, Senator. There has been much effort at the AMA beside just my Council and the Council on Medical Service. There is even a whole new department that has been set up at the AMA to study this. I know our Council, with the Council on Medical Services, has been looking at the total Medicare Program very intensively over this last 2 years, even with outside consultants and actuaries, trying to come up with solutions to this.

The CHAIRMAN. Is this a department within the AMA?

Mr. BLEHART. There is a separate department that has just been established to look specifically at the issues of quality, to try to examine situations in which the care has been provided, and then, is that care of a high quality? Also, there are existing departments that are involved in quality activities, such as the DATTA project that looks at new procedures and new therapies that are available and try to come up with terminations as to whether this type of care is appropriate.

In addition, there is the large publishing activity of the AMA that routinely publishes important information like the RAND Utilization Study that recently looked at coronary artery bypass graft surgery and looked at whether the level of care that was provided was appropriate or inappropriate. There is a massive effort to try to educate physicians on the care that they do provide.

The CHAIRMAN. When you figure out the key to hold the cost down let us know, will you?

Dr. SEWARD. Senator, This is not absolutely unique to Medicare, either. We need to look at it as part of our total health care because all health care costs are going up. One of the things that frightens me now is that there is a change in the practice of medicine. We are sending patients home now with tubes in every orifice and cannulas in arteries and veins that 15 years ago—if they had all those cannulas—I'd have them in intensive care units. The technology of how we treat people has changed. This will continue to be so. I think we have to look very closely at the appropriateness. The problem sometimes is that when you do that in retrospect, it is exceedingly difficult. Exceedingly difficult.

The **Chairman**. You indicated in your testimony that because of PPS, under Part A of Medicare, the average stay in hospitals had decreased. Therefore, there might be—an increase in some services provided under Part B. Have you experienced that?

Dr. **Seward**. Yes, I do.

The **Chairman**. Do you think the Prospective Payment System is a good thing?

Dr. **Seward**. The answer there is still not completely in on that. I think in some areas that I have seen, yes, they were. Something had to be done to help address the rising hospital costs, too. And I think that looking at certain hospital services and trying to bundle those has a certain appropriateness. However, the individual patient, again, is what I worry about. Any time you run anything by an average there are going to be individual patients on each side that may experience a real problem. That is where, as a family physician, I have problems.

The **Chairman**. I think what is bothering older Americans is how they're going to keep up with increasing care costs. Many older Americans living on limited, fixed incomes, are concerned about the increasing cost of hospital care, prescription drugs, and physicians' services. Part B is, in many ways, only a small part of the increasing health care costs across the board.

I thank you very much for your testimony, Doctor. I hope that in the work that the AMA does you can keep us advised on your recommendations as you go along. I well realize that you do have groups within that that are very much concerned about the same things we're concerned about. I think we do have testimony submitted by the American Society of Internal Medicine, and we'll be making that part of the record.

[Statement of the American Society of Internal Medicine follows:]

STATEMENT OF THE

AMERICAN SOCIETY OF INTERNAL MEDICINE

TO THE

SENATE SPECIAL COMMITTEE ON AGING

ON THE

MEDICARE PART B PREMIUM FOR 1988

NOVEMBER 2, 1987

Recently, the Reagan Administration released figures that project that the premiums patients must pay for Medicare Part B coverage (the supplemental part of Medicare that covers physicians' services; services of certain non-physician health care professionals; medical devices; and clinical laboratory services) will increase on January 1, 1988 to $24.80 per month, a 39 percent jump over 1986 premiums. The increase has been largely attributed to a 20 percent increase in Medicare expenditures for services covered under Medicare Part B, although--as discussed later--this is but one part of the explanation for the rise in the premiums.

This announcement has generated understandable concern among beneficiaries, physicians, government officials and members of Congress. The American Society of Internal Medicine (ASIM), which represents those physician specialists in adult medical care that treat 43 percent of the Medicare population, strongly shares those concerns. Our members are acutely aware that the premium increase--about $85 per year--will impose hardship on many of their financially-disadvantaged patients--and in the worst cases could result in some patients dropping their Medicare coverage. This is a result that everyone must (or should) be committed to preventing.

But we are also very concerned that some people--including people in influential positions who should know better--are reacting in an ill-advised, rash and kneejerk manner, by placing all of the blame on physicians and calling for "tight limits on physician fees." That may be the politically popular thing to say. But unfortunately, it is the wrong answer to the problem--wrong because it misrepresents the facts, wrong because it will not work (most physician fees actually were frozen and thus could not have anything to do with the current cost or premium increases), and wrong because it is unfair. And it is wrong because it creates an atmosphere of confrontation and polarization, rather than an environment where we can all work together to develop constructive approaches to the problems facing Medicare patients.

A good place to begin is by putting aside "finger-pointing" and "blame-placing" and instead look at what we know--and of equal significance, don't know--about what's going on. *A look at the facts suggests that a variety of factors have had some role in the premium increase, including the government's decision to keep premiums artifically low in prior years; new laws enacted by Congress that increased costs (including expansion of benefits for services of non-physicians); a desirable and intended shift of services out of expensive hospitals into less costly physician offices; an increase in the over-65 population and, in particular, those over 85 (who generally require more services); continued improvements in patient care; and greater access to physician services because of the growing supply of physicians. It is equally clear, however, that much is still not known about how much each of these (and other factors yet to be identified) may have contributed to the premium rise.*

On September 15, Glenn Hackbarth, Deputy Administrator for the Health Care Financing Administration (HCFA)--the agency that administers Medicare provided ASIM with the facts. Here is what we learned.

FACT: The estimated 1988 Part B premium increase is almost double the increase in Medicare spending--39 percent compared to 20 percent. This means that although increased program costs in 1987 are--and should be--a matter of concern, they explain only half of the premium increase.

FACT: The "prime reason" that the premiums are rising in 1988 at twice the rate of government spending for the program, according to Mr. Hackbarth, is that the government for the prior two years artificially kept premiums below what they should have been to provide adequate revenue for the program. In 1986, premiums did not increase at all; in 1987, they should have been set at $2.86 per month higher than they are today. By dipping into reserves rather than raising the premiums, the government has run out of money. Now, the bill has come due--meaning that beneficiaries are being hit all at once for a large premium increase rather than having smaller increases spread out over three years. Is it any wonder that the increase is "unprecedented?"

FACT: Medicare spending for the twelve months ending June 30, 1987 apparently has increased by 20 percent over the prior twelve months (July 1, 1985-June 30, 1986), but the government itself knows little about why this has occurred. But what we do know is that physician fees--what physicians are charging their Medicare patients--have virtually nothing to do with the increase. Here is the best information available at this time, based on what Mr. Hackbarth himself acknowledges is a "crude analysis" of the 20 percent increase (apparently, we won't really know for sure what is going on for another nine to twelve months.)

2% of the increase is due to MORE MEDICARE BENEFICIARIES than the prior twelve months, the result of an aging population. Obviously, nothing can be done about this part of the cost increases.

+ 2% is due to a new law passed by Congress that requires PROMPT PAYMENT of Medicare claims. Congress passed this law because patients were waiting as long as six weeks to get reimbursed by the program--something everyone agreed was unacceptable. The result is that Medicare paid more claims in 1986-87 rather than delaying and paying them in the following year as they had done in the past. Again, nothing could be done about this portion of the increase, unless Congress just ignored the problem of slow payment.

+ 7% of the increase is due to Congress' decision to UPDATE MEDICARE PAYMENTS to patients, physicians, suppliers, laboratories and other non-physician providers (the so-called Medicare "allowable charge")--the first increase in payments in almost four years for most physician services since Congress, in 1984, froze payments for most physician services until 1987 at July 1, 1983 levels.

Subtotal: 11% which represents the amount of the cost increase due to demographic changes (aging population) and laws Congress itself enacted to correct problems in the Medicare program. (It is unfortunate that some members of Congress are now blaming physicians for the cost of laws they themselves enacted).

+ 9% represents MORE SERVICES provided to Medicare patients (the so-called "utilization," "volume" or "intensity" increases). This factor--which represents less than half of the overall cost increase--is the only one that can be directly attributable to physicians, at least in part, since they order many (but not all) medical services for their patients. But "more services" does not necessarily mean "unnecessary services," as discussed below.

Total 20% total increase, July 1, 1986 through June 30, 1987.

FACT: The 7 percent portion of the increase in Medicare payments (discussed above) for Part B covered services has absolutely nothing to do with charges or fees (how much physicians charge for their services), except for the neglible impact of the minority of physicians who agreed to accept Medicare's "approved amount" for all services (participating physicians) and thus were exempted by Congress from the fee freeze. The fees of all other physicians were frozen by law from July 1, 1984 through December 31, 1986, and remain under tight controls that limit most fee increases to one percent (and in some cases require reductions in fees). It is disingenous, to say the least, for members of Congress to now call for "tight new limits on fees" when they know that fees have been subject for most of the past three years to the toughest limits of all--an outright freeze--and therefore have nothing to do with the recent premium or cost increases.

FACT: Comparing cost increases for the twelve months ending June 30, 1987 with the prior twelve months ending June 30, 1986, is misleading for several important reasons:

o Congress passed several laws in 1986 that they knew would increase costs in 1987; including the prompt payment provisions and the updates in Medicare payments (discussed above). They also added new benefits for non-physician services--physicians' assistants and optometrists--that have some impact (amount unknown) on the increased costs. The costs of these new benefits specifically would be included in the 7 percent increase in Medicare payments and the 9 percent increase in services. On January 1, 1987, Congress also authorized Medicare to pay 100 percent of the allowable for all lab tests, instead of the prior 80 percent for tests if physicians or labs did not accept assignment for services--which also would contribute to spending increases.

- Almost all of the congressionally-mandated increases in Medicare payments were associated with the twelve months ending June 30, 1987, not during the prior twelve months. In the twelve months ending June 30, 1986, only one increase in payments for physicians' services took place, and that was a 4.1 percent increase in payments to participating physicians' (those who agreed to accept Medicare payments in full) on May 1, 1986--meaning that those increased costs were included only in the last two months (May-June, 1986) of that twelve month period. By comparison, the 4.1 percent increase for participating physicians was in effect for the entire twelve months ending June 30, 1987, and the additional 3.2 percent increase on January 1, 1987 for all physician services was included in the costs for fully half of that latter twelve month period (January-June, 1987). Therefore it is not at all surprising that there were substantially increased costs from one year to the other.

FACT: Much of the 9 percent increase in services provided to beneficiaries has been attributed by the government to Medicare's new way of paying hospitals, which encourages the treatment of patients in the less expensive physician office setting--something everyone agrees is desirable. Treating patients in a less expensive (and more convenient) setting actually saves Medicare money overall, since it reduces the high costs of hospitalization. It may also save patients money, by providing an alternative to hospitalization, thereby saving the patient Medicare's $492 hospital deductible (paid out-of-pocket by the patient before Medicare will pay anything).

FACT: Of the remaining increase in services to Medicare patients, no one knows how much of this represents improvements in patient care, services being sought by patients, and services that could appropriately be reduced without hurting patient care. Certainly some--and quite possibly most--of it represents better service: the availability of new and better technology and improved access to physician services. The increase in the numbers of physicians, "defensive medicine" resulting from the medical liability crisis, and an increase in patients over the age of 85 (who usually require more services) may also be part of the reason more services are being provided. The challenge for physicians, the Administration, Congress and others is to find ways to cut out "wasteful" and unnecessary services without eliminating needed services or stifling advancement and innovation. That challenge is not one that can be met by a "quick fix."

FACT: If nothing else, all of the above proves that new limits on Medicare payments and physician fees will not work. Congress tried this and failed: costs continued to increase during the three years that payments and fees were frozen. The same thing happened throughout the economy during the wage and price controls of the early 1970s. Several studies suggest, in fact, that price controls actually increase costs. It is ironic that some members of Congress still believe fee controls are an easy answer to Medicare's cost problem.

Summary and Conclusion:

In summary, a few final conclusions can be offered about the recently announced premium and cost increases:

1. We know relatively little about why they occurred.
2. Almost 80 percent of the Part B premium increase appears to be due to factors not directly under physician control, such as the premium "catch up," demographics, and laws enacted by Congress.
3. The one factor over which physicians do have considerable influence--the growth in services to beneficiaries--requires much more thought and discussion over how best to limit waste without endangering access to needed services.

ASIM, for its part, is committed to ensuring access to needed services. If unnecessary care is being provided, we stand willing to assist in identifying ways to eliminate misuse and overuse. We also are committed to other changes to make medical care more cost-effective. That is why we support major reforms in the physician payment system that will help reduce costs by shifting incentives away from high cost technology toward cost-effective primary care and cognitive services. That is why we have advocated innovative approaches to Medicare financing that will relieve the premium burden on beneficiaries, by putting Medicare on a fiscally sound basis and obtaining revenue from sources other than the beneficiaries themselves. And that is why we have pledged to work with the Physician Payment Review Commission to develop constructive approaches to slowing inappropriate increases in the volume of services.

But we strongly urge Congress, the Administration and others not to engage in "quick fixes" or "finger-pointing." The stakes are simply too great to allow that to happen.

/ksk
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The **Chairman**. Is the AMA participating in the RAND study?

Dr. **Seward**. Our physicians were involved with that study on coronary artery disease.

The **Chairman**. And it's an ongoing project, is it not?

Mr. **Blehart**. Yes, it is. It's still going on. The AMA has nominated individuals who have been working with the RAND study.

The **Chairman**. Thank you.

Senator Heinz.

Senator **Heinz**. Thank you, Mr. Chairman.

Doctor Seward, on page 3 of your testimony you cite Doctor McMenamin's analysis. He points out a number of what you—or he—describe as "plausible factors" for the 14 percent annual increase in physician services. Correct me if I'm wrong but I understand it's been running at that rate for quite some time.

Dr. **Seward**. Yes, sir.

Senator **Heinz**. Now, the first factor is the growth and aging of the Medicare population. What is the annual growth of the Medicare population?

Dr. **Seward**. It's about 2 percent per year right now, from what I understand.

Senator **Heinz**. What is the average increase per year in the age of that population?

Dr. **Seward**. The only thing I can tell you is that the aging of that population is increasing also. On the demographics, I don't know that exact figure, sir.

Senator **Heinz**. Isn't it reasonable to try and make an estimate of the maximum contribution that those two factors could make to this problem, and then begin to look at what's left?

Dr. **Seward**. Certainly.

Senator **Heinz**. If we have a 14 percent increase and only 2 percent of it is due to population increase, it's quite important to know what the increase in age is.

I don't know the answer to that question. I would be quite interested in trying to find out what kind of contribution that does make.

It seems to me, then, since we either don't have the information or what we have seems like a minimal increase, that it's rather difficult to maintain that those kinds of factors are the principal causative factors for increases in physician services. Would you agree with that?

Dr. **Seward**. Yes, sir. In fact, in pointing out some of those answers the AMA was very greatly concerned with that. We have added to our testimony a copy of a letter that we sent to HCFA that pertains to many of those questions you asked, trying to find some data to be able to analyze that better in that regard.

One of the things we know besides that 2 percent increase in the number of beneficiaries is that participation in the program has increased from 67 percent of beneficiaries to 76 percent between 1981 and 1986. The number of beneficiaries and their use of services has increased considerably too, sir.

Senator **Heinz**. I'm a little puzzled by some of the citations that you made from Doctor McMenamin's report. On the one hand you say that you've got some problems with it; on the other hand you cite, in the draft report, the indication that "the increase in intensity does not reflect fraudulent or improper changes in billing practices." On the issue of unbundling, the report concludes that there was "no volume response with respect to follow-up visits," whatever that means. Aren't there other ways to unbundle beside having follow-up visits?

Dr. **Seward**. Basically, Doctor McMenamin's study looked at two things, Senator. One was whether or not there was up-coding, and second, was there an increase in office visits. Whether or not there was any unbundling, I don't think Doctor McMenamin did look at that subject in and of itself. We would love to know data on whether or not there has been extensive unbundling because we are certainly not in favor of that.

Senator **Heinz**. I'm glad you clarified that because I think if someone would read your testimony they would conclude that you were using his study to say that "everything's okay with doctors; we're not going to do anything differently than we've been doing all along." Well, that may be true, since the increase has been 14 percent a year.

But let me ask you this. Obviously, everyone—the beneficiary, the taxpayer, all of us—have a very major concern about these increases. I suspect HCFA or the Congress will do something. How would you believe physicians would respond if they are faced, as HCFA proposed, with the choice of either on the one hand staying with their fee-for-service arrangement with Medicare, but with far more stringent review and cost controls, or on the other hand joining a PPO that requires that they give up some element of either economic or professional autonomy?

Dr. **Seward**. That might be a little bit like asking whether you would rather be shot or hung, and I hope that analogy is not there.

Senator **Heinz**. That bad?

Dr. **Seward**. No. Clearly, the AMA is in favor of what we call a pluralistic type of health care services where there can be HMO's, PPO's, IPA's, fee-for-service, all of this.

Senator **Heinz**. Under this scenario HCFA would give you a choice.

Dr. **Seward**. Yes, sir. I think a lot of this is purely—and rightfully so—budget-driven, dollar-driven. These are appropriate concerns for Congress and we at AMA are also greatly concerned with those. If a fee freeze is necessitated again and it is across-the-board and everything is frozen, the AMA is on record in support of freezing everything because of budget deficits.

Senator **Heinz**. Well, I guess my question is not so much whether physicians would like the choice of having one or the other but how they will tend to respond as a group. Maybe it's impossible to generalize, but thinking of yourself, if HCFA rolled up to your mailbox and dropped a little love note in it that said, "Here's your choice," the two I've given you, what would be your instinct?

Dr. **Seward**. I think I would probably go with your first suggestion. You know, some of the areas, at least in my type of——

Senator **Heinz**. The fee-for-service, but with the intensive utilization review?

Dr. **Seward**. Yes.

Senator **Heinz**. Again, with the Federal Government auditing you more stringently?

Dr. **Seward**. They have that prerogative. I can't deny that, sir.

Senator **Heinz**. For you, that would be your preference between those Hobson's choices?

Dr. **Seward**. Yes. It is a Hobson's choice.

Part of the problem is that—and I think Senator Melcher found it—when you start to direct patients specifically, a prerogative is taken away from patients on where they want to go. Second, it's interesting how payment affects how you make decisions as a physician, and I'm not sure that fee-for-services is the best way. I would not state that. But, philosophically, a worse decision is to have an economic decision based on not giving care. I personally think that possibly that is the worst choice to make on quality of care issues for patients.

Senator **Heinz**. Let me return to the subject of defensive medicine or malpractice. If it is true that some physicians use more tests—or in some sense overtreat their patients—in order to avoid liability for malpractice, how do you imagine that those physicians will respond if we give them financial incentives to do just the opposite? Will they ignore them and continue to practice defensive medicine? Will they do something else?

Dr. **Seward**. On the issue of professional liability I think you were apt in your analogy previously, that it is probably of some concern to the increase in Medicare Part B, but it certainly is not the totality by a long way, Senator.

Whether or not you set up certain guidelines and say, "this is appropriate and you don't need to do anything else and your malpractice insurance will go down," and therefore they won't order those studies, they might not until their partner or the physician down the street gets a liability suit and then I guarantee you they will start ordering those tests again.

Senator **Heinz**. Even if their reimbursement is squeezed?

Dr. **Seward**. Certainly. It is a pervasive issue and it needs to be addressed. It is not the major issue that we are talking about right now but it is an issue that certainly needs some grave concern overall.

Senator **Heinz**. Very well. Thank you very much, Doctor.

Dr. **Seward**. Thank you, Senator.

The **Chairman**. Thank you, Doctor Seward.

Our next and last witness is Ms. Martha McSteen, a senior consultant for the National Committee to Preserve Social Security and Medicare.

Ms. McSteen, please proceed.

STATEMENT OF MARTHA McSTEEN, SENIOR CONSULTANT, NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Ms. **McSteen**. Thank you, Mr. Chairman.

I would like to present just a few brief comments and then submit the full testimony for the record.

The **Chairman**. That will be fine.

Ms. **McSteen**. Mr. Chairman, I am Martha McSteen, formerly a Regional Representative for the Medicare Program in the beginning days. My long career in Social Security and Medicare culminated last year as I concluded a two and three-quarter year term as the Acting Commissioner of Social Security. But today I am pleased to appear before you representing some 4.5 million members of the National Committee. Most of those people depend upon Medicare for their primary health insurance protection.

I want to commend the Chairman and this committee for holding the hearings on the unprecedented increases in the Medicare Part B premium. Your concern and desire to protect seniors against this serious threat is appreciated by the aging community. We hope that you will introduce legislation similar to Claude Pepper's bill in the House to keep down the premium increase. We have been disappointed over what, until now, appears to be Congress' unwillingness to take action to curb the premium increase.

To limit congressional action to mere inquiries about underlying reasons for the dramatic 38.5 percent increase is to abandon seniors, telling them to fend for themselves in the face of this new erosion of their health care dollars. Without a doubt, a 38.5 percent increase in monthly premiums will have a major and adverse impact on seniors' out-of-pocket medical outlays.

The current $17.90 monthly premium is already double the premium paid in 1980. A new monthly premium of $24.80 will mean almost $83 more a year. Should the catastrophic coverage legislation become law, seniors could be asked to pay close to $345 in Part B premiums alone next year, a total of $130 increase in just 1 year. Indeed, this constitutes a serious threat to the majority of older Americans, especially when you realize the Social Security cost of living adjustment will be only 4.2 percent next year.

Mr. Chairman, clearly Congress must attack this burdensome trend by putting a stop to premium increases. We ask that you not only roll back the scheduled January increases but also act to be sure that the law becoming effective in January 1989 to require premium increases be limited to the percentage of the Social Security COLA remain unchanged.

Our members are deeply concerned about the additional cut in their Social Security checks. One member from Austin, Texas wrote, "They are taking out so much now from our Social Security that any more reductions will cause considerable hardship for people like us with very limited income outside of Social Security."

Another member took this concern a step further when she wrote to ask our advice on whether she should drop her Medicare Part B coverage because the current $17.90 a month premium took a big bite out of her meager income. Fortunately, she asked before she cancelled any Medicare premiums.

In spite of its flaws Medicare provides important coverage.

Another member now regrets his decision to drop the Part B insurance. He explains that "At the time, our financial position blinded us to the fact that someday we would regret having made this decision."

If the Medicare Part B premium already represents a terrible burden to these seniors, how many more will simply drop Part B if the monthly premium reaches $24.80, or close to $30 with catastrophic coverage? Such action portends serious disruption to our national goal of equal access to health care.

The Part B premium increase is not the only problem which results in large out-of-pocket costs to seniors. The Federal Government continues to allow physicians to charge beneficiaries higher amounts than the 20 percent Medicare allowable charge. Approximately 70 percent of all physicians charge some or all of their Medicare patients in excess of those reimbursable levels. This causes a hardship for many beneficiaries, even if they have private insurance to supplement Medicare, because few Medigap insurance plans cover more than the 20 percent co-payment.

Besides holding down the Part B premium increase, Congress should also mandate assignment. In a recent survey of National Committee members, an overwhelming two-thirds of the membership ranked as one of their top two priorities requiring doctors to accept Medicare-approved charges as payment-in-full. And unlike the Part B increase, mandatory assignment is budget-neutral.

Certainly, the increases in Medicare Part B premiums have not come as a complete surprise. Spending on the Part B Medicare program has increased at an annual rate of 17 percent over the last 10 years. The major reason for this continuing rise is physician costs. According to HCFA, 60 percent or so of the 1988 premium jump is due to increases in physician spending. We must not be misled by some of these actions. While the consumer price index grew only about 20 percent between 1981 and 1986, the median physician income grew more than 30 percent.

Furthermore, Government figures indicate that between 1980 and 1986, Medicare physicians' spending increased faster than non-Medicare physicians' spending by 60 percent. No wonder the survey of the National Committee members showed 72 percent of respondents agreed that the Federal Government should regulate doctors' and hospitals' fees.

Another reason for the large premium increase is the shift from Part A to Part B services. Nothing short of a revolution in health care took place when the DRG system was implemented. Hospital stays are shorter. Fewer and fewer procedures are deemed to require hospitalization.

The bottom line is that consumers pay the price through Part B. The premium increase is simply another piece of evidence that beneficiaries take the brunt of this fallout from the DRG revolution.

The current fee-for-service concept of medical care begs for abuse of the Supplemental Medical Insurance program by some health care providers. HCFA data shows that both the volume and the average charge for each service continue to grow. This system must be changed but changed in a manner which does not endanger quality of care.

Mr. Chairman, currently seniors pay out-of-pocket health care costs of about $1,800 per year. They ask what the $83 increase in the Part B premium will provide. The answer is, nothing additional; and further, since there is no mandated assignment policy, seniors who go to doctors who do not accept assignment will continue to pay even more out-of-pocket for Part B physicians' services. These services are essential to the well-being of seniors who have made, and will continue to make, significant contributions to this country.

Congress must pass legislation that will protect seniors from the premium increase scheduled to take effect in less than 60 days.

Thank you, Mr. Chairman, for the opportunity to appear before this committee.

[The prepared statement of Ms. McSteen follows:]

NATIONAL COMMITTEE TO PRESERVE
SOCIAL SECURITY AND MEDICARE

2000 K Street, N.W., Suite 800, Washington, D.C. 20006 (202) 822-9459

STATEMENT OF
MARTHA MCSTEEN
THE NATIONAL COMMITTEE
TO PRESERVE SOCIAL SECURITY AND MEDICARE

SUBMITTED TO
SPECIAL COMMITTEE ON AGING
U.S. SENATE

REGARDING
MEDICARE PART B PREMIUM INCREASE

NOVEMBER 2, 1987

Mr. Chairman, I am Martha McSteen, formerly a Regional Representative for the Medicare Program. My long career in Social Security and Medicare culminated last year as I concluded a two-and-three-quarter year term as the Acting Commissioner of the Social Security Administration. Today I am pleased to appear before you on behalf of the National Committee's four and a half million members, most of whom depend on Medicare for their primary health insurance protection.

I want to commend the Chairman and the members of the Committee for holding this hearing on the unprecedented increases in Medicare Part B premiums. Your concern and desire to protect seniors against this serious threat is appreciated by the aging community. We hope that you will introduce legislation similar to Claude Pepper's bill in the House to keep down the premium increase. We have been disappointed over what, until now, appears to be Congress' unwillingness to take action to curb the premium increase. To limit Congressional action to mere inquiries about underlying reasons for the dramatic 38.5 percent increase is to abandon seniors, telling them to fend for themselves in the face of this new erosion of their health care dollars.

Without a doubt, a 38.5 percent increase in monthly premiums will have a major and adverse impact on seniors' out-of-pocket medical outlays. The current $17.90 monthly premium is already double the $8.70 they paid as recently as 1980. A new monthly premium of $24.80 will mean almost $83 more a year. And should the catastrophic coverage legislation become law, seniors could be asked to pay close to $345 in Part B premiums alone next year - a total of a $130 increase in just one year. Indeed, this constitutes a serious threat to the majority of older Americans, especially when you realize the Social Security cost-of-living adjustment (COLA) will only be 4.2 percent next year.

> **Mr. Chairman, clearly, Congress must attack this burdensome trend by putting a stop to unchecked premium increases. We ask that you not only roll back the scheduled January increases, but also act to ensure that the law, becoming effective January 1989, to require premium increases be limited to the percentage of the Social Security COLA remain unchanged.**

Our members are deeply concerned about the additional cut in their Social Security check. One member from Austin, Texas, wrote, "They are taking out so much now from our Social Security that any more reductions will cause considerable hardship for people like us with very limited income outside of Social Security."

Another member took this concern a step further when she wrote to ask our advice on whether she should drop her Medicare Part B coverage because the current $17.90 a month premium took a big bite out of her meager income. Fortunately she asked us before taking such drastic and ill-advised action. In spite of its flaws, Medicare provides important coverage. Another member now regrets his decision to drop Part B insurance. He explained that "At the time our financial position blinded us to the fact that some day we would regret having made this decision." If the Medicare Part B premium already represents a terrible burden to these seniors, how many more will simply drop Part B if the monthly premium reaches $24.80, or close to $30.00 with catastrophic coverage? Such action portends serious disruption to our national goal of equal access to health care.

And the Part B premium increase is not the only problem which results in large out-of-pocket costs to seniors. The federal government continues to allow physicians to escape assignment and to charge beneficiaries higher amounts than the 20 percent of Medicare allowable charges. Approximately 70 percent of all physicians charge some or all of their Medicare patients in excess of those reimbursable levels. This causes hardship for many beneficiaries even if they have private insurance to supplement Medicare, because few medigap insurance plans cover more than the 20 percent copayment.

So, besides holding down the Part B premium increase, Congress should also mandate assignment.

In a recent survey of National Committee members, an overwhelming two-thirds of the membership ranked, as one of their top two priorities, requiring doctors to accept the Medicare approved charge as payment in full. And unlike the Part B increase, Congress cannot argue that it is unable to correct the problem because it will increase the deficit. Mandatory assignment is budget neutral.

Certainly, the increases in Medicare Part B premiums have not come as a complete surprise. Spending on the Medicare Part B program has increased at an annual rate of 17 percent over the last ten years. The major reason for this continuing rise is physician costs. According to the Health Care Financing Administration, 60 percent, or $4.05 of the $6.90 jump in the 1988 premium is due to increases in physician spending. Let us not be misled by the American Medical Association and individual physicians who complain about reimbursements from Medicare. Physicians' average overall yearly earnings are approximately $113,200 in spite of the government-imposed Medicare fee freeze. While the consumer price index grew only about 20 percent between 1981 and 1986, the median physician income grew more than 30 percent. Inflation in physician services continues to rise at a higher rate than the consumer price index. Furthermore, government figures indicate that between 1980 and 1986 Medicare physician spending increased faster than non-Medicare physician spending by 60 percent. No wonder, the survey of National Committee members showed 72 percent of respondents agreed the federal government should regulate doctors' and hospital fees.

Another reason for the large premium increase is the shift from Part A to Part B services. Nothing short of a revolution in health care took place when the DRG system was implemented in 1983 to contain hospital costs. Hospital stays are shorter. Fewer and fewer procedures are deemed to require hospitalization. With the growing demand for out-patient services, new facilities, expanded facilities, and remodeled facilities have sprung up everywhere. Services previously done under Medicare Part A are now being done under Part B in outpatient centers. Every one of these centers strives to be equipped with current and specialized equipment. The bottom line is that consumers pay the price. The premium increase is simply another piece of evidence that beneficiaries take the brunt of the fall-out from the DRG revolution. What was sold to the public as a measure of cutting the fat from medical institutions, in reality is scraping the bones of seniors' income.

The current fee-for-service concept of medical care begs for abuse of the Supplementary Medical Insurance program by some health care providers. The more times a patient is asked to come back to see the physician, the more tests and services furnished, the greater costs are incurred by the Medicare Part B program. The Health Care Financing Administration data substantiates that both the volume and the average charge for each service continue to grow. This system must be changed -- but changed in a manner which does not endanger quality of care.

Mr. Chairman, currently seniors pay out-of-pocket health care costs of about $1,800 per year. They ask what will the $83 increase in Part B premium provide? The answer is nothing! And further, since there is no mandated assignment policy, seniors who go to doctors who do not accept assignment will continue to pay even more out-of-pocket for Part B physician services. These services are essential to the well-being of seniors who have made and will continue to make significant contributions to this country. Congress must pass legislation that will protect seniors from the premium increase scheduled to take effect in less than 60 days.

Thank you, Mr. Chairman, for the opportunity to appear before this Committee.

The Chairman. Martha, your testimony reflects the concern that this committee has seen in letters we have been receiving since the announcement was made of the $6.90 monthly increase in the premium. It is a substantial increase if you are on a limited, fixed income, for no added coverage of any kind.

When you add—and I don't think people have caught up with it yet, but they will over the next several months—the costs of catastrophic coverage, that's an additional expense. Catastrophic coverage is mandatory if you participate in Part B, so you have an increase that is of some concern for those on fixed incomes.

Catastrophic coverage provides added benefits, so beneficiaries get something for the additional cost. Unfortunately, that is not true of the $6.90 increase. It's very difficult for us in Congress to justify a $7 per month increase in Part B unless we show that the Part B program has expanded. People on Social Security and other Federal retirement programs got a 1.3 percent cost of living adjustment in 1987. I know the 4.2 COLA for 1988 sounds much better, but it sort of makes up for that 1 percent increase for last year. It isn't that older Americans who are receiving Social Security have gotten much in the way of a COLA over the past few years.

I do believe that we should make some correction in this increase for Part B. I think it's too much. Whatever we do about that, however, we do have to look for the revenue to offset it. Some people have suggested today—and others have suggested for the past couple of years—that those people who are working for the governments of States and municipalities and who are not required to participate in the Medicare Program through payroll deductions, should have to do that. I believe that would be about 1.5 percent of their salary. They wouldn't be required to pay into Social Security.

How does the National Committee feel about that? Surely, when many of these people retire, they are probably going to be covered by Medicare. Shouldn't they contribute now? Should Congress make it mandatory?

Ms. McSteen. Yes. The National Committee has endorsed that concept, feeling that that is a way that part of the financing for Part B can easily come from. And at the same time it would provide protection, as you indicate, for the State and local employees in the future.

I don't think there's any one real answer to the problem. I do think that it is important that the entire Medicare Program be looked at in quite some depth, and certainly this morning you have heard, as Chair of this committee, many recommendations but no consensus. And a consensus is needed before we move ahead in this country with the health care delivery, with the health care cost containment concerns, and also equal access to health care.

The Chairman. Do you think there is consensus on imposing the 1.5 percent Medicare tax on the salaries and wages of State and municipal employees?

Ms. McSteen. I'm sure there wouldn't be consensus throughout. Maybe the State and local employees would raise some questions about it. I think the only thing that can be said in that respect is that the benefits of the Medicare Program, Part A and B both, the extent of the catastrophic proposal coverage needs to be sent in a clearer message to the general public because many members of the public do not understand the degree of coverage, their rights or their responsibilities, in my opinion.

The **Chairman**. You think we could do a better job in describing the benefits available for older Americans?

Ms. **McSteen**. Right.

The **Chairman**. Well, do you think it's fair to impose that tax?

Ms. **McSteen**. Yes, I do.

The **Chairman**. All right.

Thank you very much, Martha, for your testimony. We are indebted to you.

We will make part of the record the testimony of Jane Sisk of the Office of Technology Assessment, the statement of the Physician Payment Review Commission, and also the statement of the American Society of Internal Medicine.

With that, I want to thank all of you very much. The committee will stand adjourned.

[Whereupon, at 1:33 p.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

MATERIAL RELATED TO HEARING

ITEM 1

EXAMINING THE MEDICARE PART B PROGRAM:
AN OVERVIEW OF THE ISSUES

STAFF REPORT

SPECIAL COMMITTEE ON AGING

UNITED STATES SENATE
JOHN MELCHER, CHAIRMAN

November 2, 1987

83-915 0 - 88 - 5

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I. EXECUTIVE SUMMARY

The following report presents an overview of the Medicare Supplemental Medical Insurance (SMI) program, also known as Part B. This part of the Medicare program, which covers primarily physicians' services, and hospital outpatient services, has received a great deal of attention lately as a result of the unprecedented 38.5 percent increase in the monthly premium. This report was written to provide a compendium of the information currently available on the SMI program, and to provide a framework for the discussion of possible alterations to the present system.

Highlights of the report include:

o Part B enrollees out-of-pocket expenses have increased 211 percent since 1973.

- Twenty-four percent of total Medicare outlays in fiscal year 1986 were for physicians' services; this is expected to reach 27 percent of program outlays by fiscal year 1988.

- The Health Care Financing Administration reports that 60 percent of the $6.90 increase in the monthly SMI premium is due to growth in reimbursement to physicians.

- In the years between 1983 and 1986, physician expenditures under Medicare increased at an annual rate of 9.1 percent, compared to 7.2 percent for all physicians.

- Physician payment reform options, as detailed by the Office of Technology Assessment, the Physician Payment Review Commission, and others include modifying the current system, the development of a fee schedule, "bundling" of services, and capitation.

II. BENEFICIARY COST-SHARING AND THE SUPPLEMENTAL MEDICAL INSURANCE (SMI) PROGRAM

Since 1973, aged SMI beneficiaries' liability for out-of-pocket payments has increased by 211 percent, from $134 per enrollee in 1973 to $417 per enrollee in 1985. Between those years, the proportion of enrollees' out-of-pocket liability that was due to SMI premium payments declined from 52 to 45 percent. However, in that same time period, the proportion of their out-of-pocket liability due to SMI coinsurance payments almost doubled, from 21 to 41 percent. Of the total out-of-pocket expenditures by persons age 65 and over in 1984 ($1,059), 21.4 percent, or $227, was for physicians' services.

According to a March, 1986, report from the Harvard Medicare Project, the total amount that beneficiaries pay in copayments has increased 50 percent faster than older American's incomes in the past decade.[1] The report estimates that a beneficiary requiring hospitalization today will incur an average copayment liability of $1,000 for that care. For the elderly living at or below the poverty line (approximately 12 to 15 percent of the elderly population) this is one-fifth of their annual income for a single episode of illness. Further, these extensive copayment requirements make it difficult for the elderly to plan for their health care expenses. Because beneficiary copayments are based on cost of services that have been utilized, out-of-pocket expenses are as difficult to anticipate as the illness itself.

The Medicare Part A (Hospital Insurance) deductible has increased by 155 percent since 1981, from $204 to $520 in 1987; this increase is more than five times the general inflation rate during this period. The Part B premium was $9.60 in 1980; in 1988, the premium will be $24.90, an increase of nearly 160 percent. According to the Prospective Payment Commission's (ProPAC) April, 1987 report to the Secretary of the Department of Health and Human Services, "cost-sharing borne by Medicare beneficiaries has inadvertently increased as a result of PPS [the Prospective Payment System]."[2] The cost savings realized from PPS have been shared with hospitals and the Medicare program, but not with beneficiaries.

ProPAC reports that PPS incentives to shift services from the inpatient setting to ambulatory settings and to discharge patients after shorter hospital stays may also affect beneficiary out-of-pocket spending.[3] Medicare coverage varies by place and by type of treatment, so coinsurance liability can change depending on where the service is provided. For example, if a surgery is performed in an outpatient setting as opposed to an inpatient hospital setting, beneficiary cost-sharing liability would usually be less. However, if a beneficiary is treated as an inpatient but is then discharged earlier for additional treatment on an outpatient basis, the beneficiary must then pay for the coinsurance of the outpatient facility (under Part B) as well as the inpatient hospital deductible (under Part A). Further, there may be some services that would be covered in an inpatient setting but not in an outpatient one.

A beneficiary who has surgery in an outpatient hospital department is responsible for 20 percent of the facility's charges. Charges for the surgery would have to be at least $2,600 for a beneficiary to incur more than $520 (the inpatient hospital deductible) in coinsurance. In FY 1987, the national average facility charge for cataract surgery in a hospital outpatient department is $1,575; beneficiary liability for those charges would be $315. However, if outpatient coinsurance must be paid in addition to the inpatient deductible, which would occur if a beneficiary is released earlier from the hospital to receive additional treatment in an outpatient setting, his financial liability increases. ProPAC is currently working with the Congressional Budget Office to develop a data base for studying beneficiary cost-sharing changes and increased liability because of site-of-care substitution.

In 1984, between 64 and 75 percent of the noninstitutionalized elderly (16 to 19 million people) had some type of supplemental insurance coverage. Although benefits vary, individual or group Medigap insurance was the most common type of coverage. Medicare beneficiaries who are younger, have higher incomes, live with their spouses or who are employed are more likely to have group insurance. A 1982 survey conducted by HCFA and SRI International found that those who need supplemental coverage the most because they cannot cover the costs of major illnesses are the least likely to have it.

III. THE MEDICARE SMI PROGRAM

Part B of the Medicare program (or Supplemental Medical Insurance) covers physicians' services, outpatient hospital services, physical therapy, diagnostic and X-ray services, and durable medical equipment and certain other services. SMI is a voluntary, non-means-tested program, and anyone eligible for Part A Hospital Insurance and anyone over 65 can obtain Part B coverage by paying a monthly premium ($17.90 in 1987).

In 1985, about 27 million elderly and 3 million disabled persons were entitled to Part A benefits. Nearly all of the aged and about 92 percent of the disabled opted for Part B coverage. Between 1981 and 1985, growth in the Medicare enrollment rate for the aged averaged just over 2 percent annually. This rate is expected to decline slightly and then accelerate as the baby-boom generation begins to reach age 65 in about 2010.

Federal Outlays. Total Medicare outlays in FY 1986 were $75.9 billion; of this amount, $49.7 billion were Part A outlays and $26.2 billion were Part B outlays. This represented about 8 percent of the entire federal budget and almost 2 percent of GNP. Of Part B outlays in FY 1986, reimbursement for physicians' services represented 75 percent of Medicare Part B outlays ($18.8 billion, or 24 percent of total Medicare expenditures). The Administration estimates that, in the absence of legislation, payments for physicians' services will total $23.8 billion in FY 1988, which will be 27 percent of total Medicare outlays. Medicare payments represented 18 percent of all physicians' incomes in 1982. This number, however, varies by specialty. Thoracic surgeons reported 35 percent and internists 29 percent of gross earnings from Medicare compared with 15 percent for family practitioners.

Financing and Beneficiary Cost-Sharing. The SMI program is financed by a combination of beneficiary premiums, general revenues and SMI trust fund interest. Beneficiaries must pay a monthly premium of $17.90 in 1987, or $214.80 per year, up from $36 per year in 1966. Before SMI benefits begin, beneficiaries must meet an annual deductible of $75 paid against charges allowed by Medicare. Once the deductible is met, the beneficiary is liable for 20 percent of Medicare allowable charges for covered physician services. **There is presently no upper limit or cap for coinsurance liability.** In other words, if a beneficiary incurs physician expenses of $5,000, he/she is liable for at least a $1000 copayment; that figure could be much higher if some of the charges are not "allowed" by Medicare.

Until 1972, premiums for SMI were to cover half of program costs and general revenues the rest. As outlays increased during the early years of the program, Congress limited increases in beneficiary premiums to the percentage of cost-of-living increase in Social Security cash benefits. This changed in 1984, and for the five-year period beginning January 1, 1984, enrollee premiums must equal 25 percent of the estimated costs of coverage for the aged. Because contributions from general revenues must make up the difference between premium income and program costs, the solvency of the SMI trust fund is not directly endangered by rising outlays. Instead, the burden falls on general revenues, contributing to the budget deficit.

The Part B program is financed on an accrual basis with a contingency margin; in other words, it is a "pay as you go" program, and is financed through premiums paid by current beneficiaries. The Part B trust fund should always be somewhat greater than the claims that have been incurred by enrollees but not yet paid by the program. The extra funds are called a "contingency reserve"; the amount varies, but is generally equal to approximately one to two months of funding to cover any error in forecasted expenditures. It is up to HCFA to determine how much of a contingency reserve is desirable; it is not determined by any regulations or statutes.

IV. THE MEDICARE SMI MONTHLY PREMIUM INCREASE

The Health Care Financing Administration published in the Federal Register notice of the 1988 monthly Medicare Part B premium rates, which will be increased from $17.90 to $24.80. According to HCFA, this $6.90 increase (38.5 percent) is the result of several factors:

• Contingency reserve spend-down in 1987	$1.43	20.7%
• Contingency reserve build-up in 1988	$0.07	1.0%
• 1987 expenditures exceeding projections	$2.40	34.8%
• Projected expenditure increase, 1987-88	$3.00	43.5%
	$6.90	100.0%

For the past few years, the computation of the monthly Part B premium has taken into account a surplus in the trust fund. As a result, the monthly premium has been artificially low because it was adjusted downward to reflect the surplus. For example, the 1987 premium would have been $19.30 rather than $17.90 if projected expenditures had not been partially funded by drawing down the contingency reserve. For calendar year 1988, however, that surplus no longer exists, and $1.43 of the $6.90 increase reflects that.

Additionally, HCFA's projections for 1987 were inaccurate, and incurred expenditures for 1987 are 12.1 percent higher than projected. This 12.1 percent discrepancy accounts for $2.40 of the increase. Of this amount, increases in reimbursement to physicians account for more than 90 percent of the increase. Finally, HCFA's actuarial estimates show Part B expenditures increasing 13.9 percent in 1988. This growth accounts for $3.00 of the $6.90 premium increase; 63 percent of this increase is the result of projected increases in physician expenditures. HCFA, then, states that almost 60 percent of the premium increase ($4.05 of the $6.90) is due to growth in physician expenditures.

V. PHYSICIANS AND THE SMI PROGRAM

Utilization of physician services increases with age. Approximately four out of five elderly had at least one contact with a physician in 1983, and more than 16 percent of total physician visits during 1983 were made by persons 65 years of age and older. On the average, elderly persons are more likely than younger ones to make frequent visits to a physician. This age group also visits a physician six times for every five times by the general population. The higher use of physician services by the elderly is associated with their probability of being in poor health. The majority of those who had not seen a physician in 1980 considered themselves in good health. Since the enactment of Medicare, the average number of physician contacts and the percentage of persons 65 and older reporting that they had seen a physician in the last year has increased significantly, particularly for persons with low incomes.

Medicare Physician Reimbursement. The predominant method of payment for physician services under Medicare is fee-for-service. Payment rates to physicians have been determined through a method referred to as customary, prevailing and reasonable (CPR). Under CPR, payment for each service is limited to the lowest of:

- the actual charge for the service;
- the physician's customary charge for the service;
- the prevailing charge for the service for similar services in that community set at the 75th percentile of customary charges of all physicians in that community. (The prevailing charge is adjusted by the Medicare Economic Index.)

Typically, carriers (private insurers who have been awarded contracts to administer the Part B program) do not approve the full amount a physician charges for a service provided to a Medicare patient. In the first quarter of 1985, the average reduction due to the CPR process was 26.2 percent. For example, if a physician submitted a bill for $100, approved charges would average $73.80 (80 percent, or $59.04, would be paid by the carrier). At the end of calendar year 1984, only 18.3 percent of all claims were submitted at or below CPR limits.

Medicare payments are made either directly to the doctor or to the beneficiary, depending on whether or not the physician has accepted assignment of the claim. For assigned claims, the beneficiary assigns (or transfers) his/her rights to payment from Medicare to the physician. In return, the physician agrees to accept Medicare's "approved" or "reasonable" charge determination as payment in full for covered services. The physician bills the program directly and is paid an amount equal to 80 percent of Medicare's reasonable or approved charge. The patient is liable for the 20 percent coinsurance. The physician may not charge the beneficiary (nor can he/she collect from another party such as a private insurer) more than the applicable deductible and coinsurance amounts if he/she agrees to accept assignment. The beneficiary is then protected against having to pay any difference between Medicare's approved charge and the physician's actual charge. In 1983, 56 percent of claims were paid on an assignment basis; this figure increased to 69 percent in 1985.

A physician who voluntarily enters into an agreement with HCFA to accept assignment for all services provided to all Medicare patients for a specified period, usually 12 months, is a "participating physician." However, a non-participating physician may accept or refuse requests for assignment on a bill-by-bill basis, from different patients at different times, or from the same patient at different times. However, he/she is not permitted to "fragment" bills for the purpose of circumventing the reasonable charge limitation. He/she must either accept assignment or bill the patient for all of the services performed on a single occasion.

VI. PROBLEMS WITH THE CURRENT PHYSICIAN PAYMENT SYSTEM

Even with the CPR limits, approved charges per aged Medicare enrollee increased by 591 percent between FY 1968 and FY 1983. In FY 1984, Medicare carriers processed 229 million Part B claims, or approximately 7 claims per enrollee. Total claims volume has grown at an average annual rate of 12.6 percent since 1968. Annual growth in claims per enrollee has averaged 9.4 percent.[4] From 1976 to 1982, expenditures for physician services for the elderly have increased 18 percent per year -- 2 percent from enrollment increases, 10 percent from price increases, and 6 percent in the number of services per enrollee.[5]

Most of the expenditures for physician services are for those provided in the hospital (61.9 percent in 1983). With few exceptions, most specialties have higher total billings for services provided in the hospital than in an office; internal medicine was the specialty that received the highest proportion of Medicare physician expenditures (20.4 percent of approved charges in 1981).

There is substantial geographic variation in aspects of Medicare payment, including assignment rates, annual expenditures per beneficiary, and relative values paid for certain services. There is little agreement as to how much of this variation can be attributed to expected differences in serving over 30 million enrollees in thousands of different markets, and problems regarding access, quality and efficiency.[6]

Assignment rates vary across the U.S. from a low of 17 percent in South Dakota to 87 percent in Rhode Island. In Montana, the assignment rate is 48 percent. Among Medicare's 240 charge areas, three- and four-fold differences in charges for particular procedures are common. Even within one state, charges vary widely from area to area. In Texas, a large state with a number of charge areas, the highest prevailing charge for a general practitioner's follow-up hospital visit in 1984 was approximately 2.5 times greater than the lowest.[7]

Payment rates for physician services tend to be higher in metropolitan than in rural areas, but these differences are not always uniform. In New York and Illinois, for example, charges in metropolitan areas exceeded those in non-metropolitan areas by at least 28 percent. However, in Rhode Island and Connecticut, prevailing charges in non-metropolitan counties exceeded those in metropolitan areas.

There is more than a twofold variation by carrier jurisdiction (in 1984, there were 58 jurisdictions administered by 40 carriers) in Medicare expenditures per enrollee for physician and other medical services. This variation depends on the proportion of beneficiaries who exceed the Medicare deductible and are then eligible for reimbursement. That number depends on variations in health, volume of services, physicians' charges, and the Medicare carriers determination of approved charges.[8]

There appears to be significant differences in the relative approved charges for "procedural" services, which utilize medical devices and equipment, and "non-procedural" services, such as office visits, which do not.[9] For example, a physician can generate more income by providing laboratory tests or interpreting an EKG than he/she can giving advice on proper nutrition.

The establishment and maintenance of high payment rates for "high tech" services has likely contributed to these payment differentials. Many technologies are priced high when they are new because they require the use of special skills. However, after the provision of these services becomes commonplace, prices often are not reduced to reflect that.

Federal cost-containment efforts directed at controlling physician costs under Medicare have been in the form of fee freezes. Beginning in 1984, Congress implemented a 15-month freeze on physician fees. The freeze was extended several times, and was finally lifted for participating physicians on May 1, 1986 and for non-participating physicians on January 1, 1987. During the period from 1983 to 1986, physician expenditures in Medicare increased (adjusted for inflation) at an average annual rate of 9.1 percent, which is higher than the annual average for all physician expenditures of 7.2 percent.[10] This suggests that physicians may be increasing the volume of procedures and visits provided to to Medicare patients to make up for lost revenues. During 1986, expenditures for physician services in the Medicare program increased at exactly the same rate (11.1 percent) as overall physician expenditures, ten times faster than the overall inflation rate.

VII. PHYSICIAN PAYMENT REFORM OPTIONS

For the past several years, there has been a great deal of discussion and examination of possible physician payment reform options. There is little consensus on the best way to achieve this, however, there are four strategies that have received the most attention. The Office of Technology Assessment (OTA) released a study in March, 1986, entitled "Payment for Physician Services: Strategies for Medicare." This study, requested by several Congressional committees, outlines these four physician payment reform strategies:

1. Modify current fee-for-service system, limiting payments made to physicians, and adjusting the relative payment levels resulting from geographic differences, specialties, etc.

2. Payment based on a fee schedule, which would be developed using a "relative value scale" (RVS). A RVS gives each service a weight, which would be multiplied by a "conversion factor" stated in dollars. This approach would help the federal government to assess the value of services relative to one another.

3. Payment for packages of services, which is a DRG-type approach. Medicare would pay a pre-determined amount for a "bundle" of physician services depending on the diagnosis.

4. Capitation payment, in which Medicare would contract with individual providers, hospitals, health maintenance organizations, etc., to provide all services to Medicare beneficiaries for a fixed amount per year.

Further, OTA outlines a series of recommended options that address problems that are likely to continue under all the above strategies except capitation. These options include mandatory assignment, the adoption of volume controls, and the reduction of fee differentials. One of their recommendations, the formation of a physician payment commission, was adopted by Congress. The Physician Payment Review Commission was established to provide advice on a number of reimbursement issues, including the development of a relative value scale. PPRC released its first report to Congress in March, 1987, which made a number of policy recommendations, including the development of a fee schedule.

Obviously, each of these options has its own strengths and weaknesses, opponents and proponents. The development of a relative value scale, for example, would reflect individual time, skill, and the overhead costs each service requires. Ideally, a RVS would be economically neutral in terms of what services are performed, and in which setting, as well as the geographic region where the physician practices. However, it may not have a large impact on overall expenditures without adequate and simultaneous controls on intensity and volume.

Physician DRGs would give physicians, as hospital DRGs have given hospitals, the incentive to practice more efficiently since he/she would be at risk of costs in excess of the DRG. It would also address the problem of "unbundling" of services. Criticisms of this approach include concern that patient care may be jeopardized if physicians and hospitals both feel pressure to perform "efficiently." It is also possible that physician DRGs would not really lower overall expenditures because, for example, some services could be referred to outpatient settings and billed separately, or more complex cases could be broken up into two DRGs.

Capitation, already in place in the form of Medicare health maintenance organizations (HMOs) and competitive medical plans (CMPs), is an option the Administration would like to see done on a geographic basis. Geographic capitation would require Medicare to contract with an entity, such as a carrier, which would serve as the insurer for a specific geographic area. In essence, Medicare would purchase a package of services (physician services, all Part B services, etc.) for a certain price per person.

To ensure beneficiary access to care, the entity could be required to contract with a certain number or percentage of providers in a geographic area before the plan could be fully implemented. Further, certain financial incentives might be in place (such as reduced cost-sharing) to encourage beneficiary participation. If participation were mandatory for all beneficiaries, the capitation amount would be fairly easy to calculate. However, there has been very little experience with geographic capitation, and it is therefore impossible to predict its impact on beneficiaries, particularly regarding its effect on beneficiary autonomy, and access to quality care.

VIII. HEALTH EXPENDITURES IN THE UNITED STATES

In 1986, Americans spent $458 billion on health care, or 10.9 percent of GNP, compared to 10.6 percent of GNP in 1985 and 9.1 percent in 1980. Health care expenditures increased 8.4 percent from 1985 to 1986, which was slightly lower than the rate of increase in most recent years. However, after adjusting this amount for overall inflation and population growth, expenditures increased 6.3 percent during 1986, a rate much faster than in the years between 1980 and 1985. This represents real growth in health spending, which translates into an increase in service intensity. Service intensity is the area of greatest concern as it means that more technology, personnel and services are being used per capita.[11]

Americans already spend more for health care than almost any other developed nation. Data collected by HCFA on 12 nations, including Great Britain, France, Sweden and Canada, show that the United States pays the largest percentage of its gross domestic product (a measure similar to GNP) for health care; compared to our 10.9 percent, Great Britain pays 6 percent and Norway pays 6.9 percent.

National health expenditures have increased over the past fifty years in aggregate terms, on a per capita basis, and as a percent of the GNP. During the 1970's, national health expenditures grew at an average annual rate of 12.6 percent; in 1980 and 1981, it grew by over 15 percent each year. Growth in health care expenditures over the years has generally outpaced growth in the general economy. The same is true relative to price inflation -- although the Consumer Price Index (CPI) rose only 1.9 percent in 1986, the medical care CPI rose 7.5 percent. While HCFA suggests that medical care inflation can be compared more realistically to inflation in the service sector, where prices rose 5 percent in 1986, it is still a significant difference.

In the years 1980-1986, spending on the individual components of the health care market increased at widely varying rates. For example, spending for biomedical research grew at an annual rate of 7.5 percent, compared to 10.2 and 11.9 for hospital and physicians' services. Despite these varying rates of growth, patterns of expenditures and sources of funds remained fairly constant through the 1980s. Almost 40 percent of health care spending is for hospital services, and 20 is for physicians' services.[12]

Excluding spending for health by the Department of Defense and the Veterans Administration, more than 10 percent of the federal budget is spent on health ($99.4 billion in FY85). In comparison, in FY65, federal spending on this portion of the federal health budget was $1.7 billion, or 1.4 percent of the federal budget. More than 90 percent of the federal health budget is spent on the Medicare and Medicaid programs. Below is a chart illustrating the sources of national health spending for all age groups in 1965 and 1985:

SOURCE	1965	1985
Public	26%	41%
Federal	(13%)	(29%)
State & Local	(12%)	(12%)
Private	74%	59%
Patients	(44%)	(25%)
Insurance	(24%)	(31%)
Other	(6%)	(3%)
Total	100%	100%

HCFA estimates that health spending for those 65 and older averaged $4,200 per person in 1984, compared with $1,721 per person for all age groups that year. Although persons 65 years of age and older represent only 12 percent of the total U.S. population, they account for 31 percent of national expenditures for health care. Medicare paid 45 percent of those expenses incurred by the elderly; Medicaid programs, 13 percent; other public programs, 6 percent. The elderly and their families were directly responsible for an estimated 25 percent of the total health care bill. Private, third-party insurers paid the remaining 11 percent.

There is considerable variation in the source of payment depending on the type of service. Public programs paid 89 percent of hospital charges for the elderly in 1984; private funds paid 11 percent. However, private funds paid for 40 percent of expenditures for physician services.[13] While the total share of Medicare program costs paid by beneficiaries has remained fairly constant over the past 20 years, the portion paid through copayments has increased and the portion paid through premiums has decreased. Today, copayments account for about two-thirds of the costs paid by the elderly.

While the elderly, as a group, consume a disproportionate share of the health dollar, most older persons do not have exorbitantly high medical costs. A large portion of expenditures for health care among older persons is associated with persons who are in their last year of life. In a recent study, reimbursement and use of services by Medicare enrollees who died in 1978 were compared with those who survived the year. The average reimbursement for those who died was $4,909, which was four times the amount as for those who lived.[14]

IX. CONCLUSION

Medicare SMI program expenditures -- along with beneficiary out-of-pocket liability -- will undoubtedly continue to grow at the present rate unless measures are taken to control program expenditures. Increases in health care expenditures across the board in the United States demonstrate that the SMI premium increase, while possibly more dramatic than those found elsewhere in the market, is not an isolated occurrence. This is a matter of particular concern as the catastrophic legislation, which was recently passed by both houses of Congress, is expected to increase the monthly Part B premium by approximately $4.00 (effective date is unknown at this time). While this represents an expansion of benefits to Part B enrollees, it is nonetheless a premium increase, and must be taken into consideration when examining the impact of Part B on enrollees out-of-pocket costs.

Regardless of the form that changes in the current Part B program take, it is important that beneficiary concerns be given priority. In addition to limiting beneficiary liability for Part B services, beneficiary access to care must be protected, and safeguards assuring quality of care need also be in place. While most would agree that beneficiaries should shoulder their share of the burden for any changes that may be made to the system, it is equally important that policy-makers be aware of the possibility of unfairly burdening the elderly.

1 Harvard Medicare Project, Medicare: Coming of Age. A Proposal for Reform, (Boston: Harvard College, John F. Kennedy School of Government, 1986), p. 8.

2 Prospective Payment Assessment Commission, Report and Recommendations to the Secretary, U.S. Department fo Health and Human Services; April 1, 1987, (Washington, D.C.: Prospective Payment Assessment Commission, 1987) p. 48.

3 Prospective Payment Assessment Commission, Medicare Prospective Payment and the American Health Care System. Report to Congress, (Washington, D.C.: Prospective Payment Assessment Commission, 1987), p. 73.

4 U.S. Congress, Office of Technology Assessment, Payment for Physician Services: Strategies for Medicare, OTA-H-294, (Washington, D.C.: GPO, 1986), p. 41.

5 Lynn Etheredge and David Juba, "Medicare Payments for Physicians' Services," Health Affairs, Winter, 1984, p. 132.

6 Office of Technology Assessment, p. 6.

7 Office of Technology Assessment, p. 6-7.

8 Office of Technology Assessment, p. 6.

9 Office of Technolgy Assessment, p. 7.

10 Gerard F. Anderson and Jane E. Erickson, "National Medical Care Spending," Health Affairs, Fall, 1987, p. 101.

11 Anderson and Erickson, p. 98.

12 Anderson and Erickson, p. 98-99.

13 National Center for Health Statistics, R.J. Havlik, B.M. Liu, M.G. Kovar, et.al., Health Statistics on Older Persons, United States, 1986. Vital and Health Statistics, Series 3, No. 25, (Washington, D.C.: GPO, 1987) p. 76.

14 J. Lubitz and R. Prihoda, "The Use and Costs of Medicare Services in the Last Two Years of Life," Health Care Financing Review, Spring, 1984, p. 72.

ITEM 2

MEMORANDUM

TO: AGING COMMITTEE MEMBERS November 2, 1987
FR: AGING COMMITTEE STAFF
RE: BACKGROUND ON SENATE AGING COMMITTEE HEARING ON THE MEDICARE PART B PREMIUM INCREASE

On September 30, the Health Care Financing Administration published in the Federal Register notice of the 1988 Medicare Part B premium rate of $24.80 per month. This 38.5 percent increase, up from $17.90 in 1987 and 1986, is the largest in the history of the program. The hearing is being held to determine the reasons for the increase and its effect on beneficiaries. Further, it will explore ways to control Part B costs and prevent increases of this type from occurring again.

BACKGROUND

According to HCFA, this $6.90 increase is the result of several factors:

• Contingency reserve spend-down in 1987	$1.43	20.7%
• Contingency reserve build-up in 1988	$0.07	1.0%
• 1987 expenditures exceeding projections	$2.40	34.8%
• Projected expenditure increase, 1987-88	$3.00	43.5%
	$6.90	100.0%

The Part B program is financed on an accrual basis with a contingency margin; in other words, it is a "pay as you go" program, and is financed through premiums paid by current beneficiaries. The Part B trust fund should always be somewhat greater than the claims that have been incurred by enrollees but not yet paid by the program. The extra funds are called a "contingency reserve," which is an amount equal to approximately one to two months of funding to cover any error in forecasted expenditures. It is up to HCFA to determine how much of a contingency reserve is desirable; it is not determined by any regulations or statutes.

For the past few years, the computation of the monthly Part B premium has taken into account a surplus in the trust fund. As a result, the monthly premium has been artificially low because it was adjusted downward to reflect the surplus. For example, the 1987 premium would have been $19.30 rather than $17.90 if projected expenditures had not been partially funded by drawing down the contingency reserve. For calendar year 1988, however, that surplus no longer exists, and $1.43 of the $6.90 increase reflects that.

Additionally, the projections for 1987 were inaccurate, and incurred expenditures for 1987 are 12.1 percent higher than projected. This 12.1 percent discrepancy accounts for $2.40 of the increase; of that amount, increases in physician expenditures account for more than 90 percent. Finally, HCFA's actuarial estimates show Part B expenditures increasing 13.9 percent in 1988. This growth accounts for $3.00 of the $6.90 premium increase; 63 percent of this increase is the result of increases in physician expenditures. HCFA, then, states that almost 60 percent of the premium increase ($4.05 of the $6.90) is due to growth in physician expenditures.

GENERAL INFORMATION ON PART B

Part B of the Medicare program (or Supplemental Medical Insurance) covers physicians' services, outpatient hospital services, physical therapy, diagnostic and X-ray services, and durable medical equipment and certain other services. SMI is a voluntary, non-means-tested program, and anyone eligible for Part A Hospital Insurance and anyone over 65 can obtain Part B coverage by paying a monthly premium, which is $17.90 in 1987.

In 1985, about 27 million elderly and 3 million disabled persons were entitled to Part A benefits. Nearly all of the aged and about 92 percent of the disabled opted for Part B coverage. Between 1981 and 1985, growth in the Medicare enrollment rate for the aged averaged just over 2 percent annually. This rate is expected to decline slightly and then accelerate as the baby-boom generation begins to reach age 65 about 2010.

Federal Outlays. Total Medicare outlays in FY 1986 were $75.9 billion; of this amount, $49.7 billion were Part A outlays and $26.2 billion were Part B outlays. This represented about 8 percent of the entire federal budget and almost 2 percent of GNP. Of Part B outlays, 72 percent (75 percent of Part B expenditures for services) represented payment for physician services ($18.8 billion). The Administration estimates that, in the absence of legislation, payments for physicians' services will total $23.8 billion in FY 1988, which will be 27 percent of total Medicare outlays. Medicare payments represented 18 percent of all physicians' incomes in 1982 (CRS data).

Financing and Beneficiary Cost-Sharing. The SMI program is financed by a combination of beneficiary premiums, general revenues and SMI trust fund interest. Beneficiaries must pay a monthly premium of $17.90 in 1987, or $214.80 per year, up from $36 per year in 1966. Before SMI benefits begin, beneficiaries must meet an annual deductible of $75 paid against charges allowed by Medicare. Once the deductible is met, the beneficiary is liable for 20 percent of Medicare allowable charges for covered physician services. There is no upper limit or cap for coinsurance liability. In other words, if a beneficiary incurs physician expenses of $3,000, he/she would be liable for at least a $600 copayment; that figure could be much higher if some of the charges are not "allowed" by Medicare.

Until 1972, premiums for SMI were to cover half of program costs and general revenues the rest. As outlays increased during the early years of the program, Congress limited increases in beneficiary premiums to the percentage of cost-of-living increase in Social Security cash benefits. For the five-year period beginning January 1, 1984, enrollee premiums must equal 25 percent of the estimated costs of coverage for the aged. Because contributions from general revenues must make up the difference between premium income and program costs, the solvency of the SMI trust fund is not directly endangered by rising outlays. Instead, the burden falls on general revenues.

ITEM 3

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United States Senate
SPECIAL COMMITTEE ON AGING
WASHINGTON, DC 20510-6400

November 10, 1987

William L. Roper, M.D., Administrator
Health Care Financing Administration
200 Independence Avenue S.W.
Washington, D.C. 20201

Dear Bill:

I appreciated your testimony on the Part B Premium increase before the Senate Special Committee on Aging last week and want to follow-up personally with two questions.

First, as requested at the hearing and following up our discussion on how Part B costs had far outstripped the Medical Care CPI, I would appreciate your sharing with me and the minority staff HCFA's analysis identifying the underlying correlates and reasons for the large percentage annual increase in Part B benefits per enrollee.

Second, it would be extremely helpful to learn what steps HCFA is taking to develop and incorporate better and more reliable standards and measures of quality in physician services into its strategy for controlling Part B expenditures. Obviously, your comment that this process could take up to two years is worrisome, knowing that the Administration and the Congress will be under pressure to control physician expenditures more rapidly than that. In principle, moving to control expenditures before we have the ability to monitor the impact of cost controls on quality and patient outcomes risks the quality of medical care. Can quality review be implemented concurrent with and as an integral part of physician payment and utilization review reforms, and, if so, how and what should be done now?

I appreciate your indicated willingness to respond quickly to the problem of rising Part B expenditures and look forward to working cooperatively on solutions that account to both cost and quality concerns.

Sincerely,

John

JOHN HEINZ
Ranking Member

JH/nhs

DEPARTMENT OF HEALTH & HUMAN SERVICES
Health Care Financing Administration

The Administrator
Washington, D.C. 20201

JAN 7 1988

The Honorable John Heinz
Special Committee on Aging
United States Senate
Washington, D.C. 20510

Dear Senator Heinz:

Thank you for your letter following up my November 2 appearance before the Committee concerning the Medicare Part B premium increase. I apologize for the delay in my response.

You requested that I share with you my analysis of the causes underlying the large annual increase in Part B benefit spending per enrollee. Part B spending per enrollee increased by 15.7 percent in 1986 and 17.1 percent in 1987, while the medical component of the Consumer Price Index (CPI) increased by only 7.5 percent in 1986 and 6.6 percent in 1987. For 1988, current actuarial estimates project an increase in Part B benefit spending per enrollee of 13.5 percent, while the medical component of the CPI is projected to increase by 6.2 percent. Although it is virtually impossible to quantify each reason for this difference, the growth in Part B spending per enrollee over and above the medical component of the CPI is due to increases in the utilization or volume of services, changes in the reported mix and intensity of services, changes in technology, and legislation affecting Medicare services. Physician services, representing about 65 percent of total Part B payments, account for the major portion of increased spending.

You also expressed interest in HCFA's activities in integrating the use of quality standards for physicians services into our efforts for controlling Part B expenditures. As you know, the peer review organizations (PROs) are primarily reviewing the quality of care provided to Medicare beneficiaries in hospitals and health maintenance organizations (HMOs). Generic screens assist in identifying inappropriate instances or patterns of hospital care and alert PROs of a potential need for more focused, intensified review. PROs also focus review on areas where their data and research indicate problems may exist. Where problems are identified, the PRO works with the hospital, HMO, and/or physicians to assure that corrective action is taken.

PROs will deny payment for any care of substandard quality when regulations implementing this provision are issued. In the third contract cycle, PROs will also review surgical procedures performed in ambulatory surgical centers and hospital outpatient departments, and intervening care provided to patients who are readmitted to a hospital within 31 days of discharge. This has already been implemented in the Pennsylvania PRO.

Review of physician services provided in other settings is delayed, by provisions of the Omnibus Budget Reconciliation Act of 1986, until January 1, 1989.

I hope this information will be helpful to you. Please let me know if I can be of any additional assistance.

Sincerely,

Bill

William L. Roper, M.D.
Administrator

ITEM 4

TESTIMONY OF JANE E. SISK

OFFICE OF TECHNOLOGY ASSESSMENT

U.S. CONGRESS

ON MEDICARE PHYSICIAN PAYMENT REFORM

FOR THE SPECIAL COMMITTEE ON AGING

U.S. SENATE

The Administration's recent decision to raise the 1988 premium for Medicare's Supplementary Medical Insurance Program (Part B) 38.5 percent over its 1987 level reflected estimates of trust fund reserves and medical care expenditures. Starting in 1984, when Medicare began to pay prospectively for inpatient operating costs, the increase in Part B costs per enrollee slowed markedly. Part B costs per enrollee grew on average 13.4 percent annually from 1976 to 1986, but only 5.4 percent during 1985, the first year physicians' fees were frozen. Higher growth rates resumed in 1986, reaching 9.3 percent, despite continuation of the fee freeze. Estimates for 1987 range from 17 percent by the Health Care Financing Administration (HCFA) to 14 to 16 percent by the Congressional Budget Office (CBO). HCFA predicts a return to the historical trend in 1988, with annual Part B growth of 13 percent per enrollee. (Gramlich, 1987).

Because physician services account for almost three-fourths of Part B expenditures (U.S. House, 1987), the resumption of double-digit increases in Part B has heightened interest in methods to reform Medicare payment for physician services. This testimony outlines problems with Medicare's current payment arrangements and analyzes the implications of four possible strategies for reform: modifications to the present system of paying by customary, prevailing, and reasonable (CPR) charges; payment based on fee schedules; payment for packages of related services; and capitation payment. This review is drawn from a report by the Office of Technology Assessment entitled Payment for Physician Services: Strategies for Medicare, which was mandated by Public Law 98-369 and requested by the Senate Special Committee on Aging.

CURRENT PAYMENT ARRANGEMENTS

Under the CPR system of determing payment rates, Medicare pays the lowest of the charge that a physician bills for a service (billed charge), the charge that the physician customarily billed in the past year (customary charge), or a measure of the customary charges of peer physicians in the same locality (prevailing charge). A beneficiary is generally liable for an annual deductible and 20 percent coinsurance. If a physician accepts assignment, that is, agrees to accept Medicare's approved charge as payment in full, the beneficiary has no additional liability. Otherwise, the beneficiary is liable for any excess of the physician's total charge over Medicare's approved charge.

Because Medicare's payment rules are complex, providers and beneficiaries alike find the CPR system very confusing. It is clearly inflationary, because approved charges are based on what physicians have charged in the recent past (Lee and Hadley, 1981). Like other payers of physicians services, Medicare has set relative rates that reward urban, specialist, inpatient, procedural, and new services much more highly than rural, generalist, ambulatory, nonprocedural, and established services. And like other methods of fee-for-service payment, the CPR system contains incentives for physicians to perform additional services if the extra revenue covers the physicians' costs.

Recent concern has centered on increases in volume of services, which accounted for 95 percent of expenditure growth in 1986, when fees were frozen (Gramlich, 1987). The extent to which physicians react to lower prices by stimulating the use of their services has not been resolved (Reinhardt, 1985). Physicians might reduce the quantity of services that they were willing to provide, or they might induce demand for their services, thereby increasing the volume of services used. The ultimate effect on Medicare expenditures from lowering its payment rates would depend on the size as well as the direction of the quantity response.

The growth in physician supply and in innovative practice arrangements further complicates predictions about the effects of payment changes. Physicians are increasingly entering practice arrangements that control their incomes and use of services and may be more willing to accept lower prices for their services and lower increases in their incomes. Physicians in the United States and Canada, however, have maintained their income levels even in the face of substantial increases in physician supply (Barer, et al., 1985).

Beneficiaries' financial access to care depends partly on physicians' willingness to accept assignment if Medicare's payment rates are reduced. Overall beneficiary access would improve with an increase in assignment rates and decline with lower assignment rates. Physicians have been more likely to accept assignment the higher Medicare's approved charge relative to their billed charges, and similar considerations influenced physicians' decisions to become participating physicians (to accept assignment on all claims) (Cotter and Willer, 1985).

Despite expectations, assignment rates have risen as the percentage of the billed charge paid by Medicare has fallen. From 1976 to fiscal year 1986, assignment rose from about 50 percent to about 69 percent of claims and charges (US Congress, 1983; US DHHS, HCFA, 1986).

MODIFICATION OF PRESENT PAYMENT ARRANGEMENTS

Payment of Inherently Reasonable Rates

The appropriateness of Medicare payment rates for certain services has been challenged on several grounds. Sizable differentials exist across geographic areas, physician specialties, sites of service, and types of service. In general, payment rates for urban, specialist, inpatient, and procedural services substantially exceed those for rural, generalist, ambulatory, and nonprocedural services. These differentials raise the concern that they may be affecting the quality of care received by beneficiaries and the costs of care paid by Medicare and beneficiaries.

Medicare carriers make no geographic distinctions in 18 states, but use 28 localities in California and 32 in Texas (US DHHS, HCFA, 1984). Although differentials in recognition of local market conditions are warranted, even after adjustment for cost-of-living differences, Medicare prevailing charges in 1975 averaged 17 percent above the national average in the largest urban areas but 8 percent below in the least densely populated counties (U.S. Congress, 1983).

Payment rates also differ between specialists and generalists, chiefly for visits and sometimes by as much as 50 percent (US Congress, 1983). Carriers for three states and parts of two others do not distinguish among physician specialties (O'Sullivan, 1984), while South Carolina has 33 and Pennsylvania 58 different groupings. In 1982, the prevailing charges for different types of visits averaged 24 to 73 percent higher for internists than for general practitioners (U.S. DHHS, HCFA, 1985).

One might argue that higher payments rates for certain procedures can be justified for some physicians. When physicians practice in the area of medicine for which they were specially trained (modal specialists), they may provide higher quality care than physicians without such training (Payne, 1976). But many "specialty" procedures, such as cataract surgery, already have Medicare approved charges that are, in fact, specialty specific. Because those procedures are performed by relatively few physicians outside of the relevant specialty, the charges of physicians outside that specialty have little effect on the level of the Medicare approved charge. The justification for specialty differentials is especially difficult in the area of office and hospital "visits" where it is questionable that sufficiently different services are being performed by specialists to warrant higher payments.

Visits are among the most frequently performed procedures of most specialties participating in Medicare, and constitute nearly one third of all Medicare approved charges (Juba, 1987). In any case, the common practice of allowing physicians to declare themselves specialists and reap higher payment rates is questionable (US Congress, GAO, 1984).

Another basis for disputing CPR-determined rates is that the provider's costs of performing a new procedure often fall over time, as more physicians and technicians acquire once-rare skills, techniques become more refined and the procedure faster, and high fixed costs of expensive equipment are spread over a larger volume of services. Within the CPR charge system, however, the early submitted charges establish the relative rate paid, and rates for expensive technologies, such as open-heart surgery and cataract excision, tend to remain at initial levels or to increase, even if the costs of using them decline over time.

The downward stickiness of rates paid for new, expensive technologies adds to the large differences in payment rates between procedural and nonprocedural services. Even after adjustments for complexity, resource cost, and training, physicians have been paid four to five times more per hour for inpatient surgery than for office visits (Hsiao and Stason, 1979). There is no concensus on the point at which these differences become discrepancies or on the "correct" relationship between payment rates for procedural and nonprocedural services. The policy concern is that relative payment rates may encourage physicians to provide procedural services with little or no benefit to patients and to slight nonprocedural services such as counseling that might benefit patients greatly.

Beneficiaries may have more difficulty obtaining nonprocedural than procedural services. Medicare has paid a lower percentage of physicians' billed charges for visits than for surgery; primary-care specialists (family and general practitioners and internists) have accepted assignment at lower rates than surgical specialists; and beneficiary 's liability has been a greater portion of payments to primary-care physicians than to surgeons and radiologists (Juba, 1987).

The Consolidated Omnibus Budget Reconciliation Act of 1985 and the Omnibus Budget Reconciliation Act of 1986 (OBRA) permit Medicare and its carriers to set rates different from those determined by the CPR system. In defining "inherently reasonable" rates, Medicare may consider factors such as geographic differences in charges, costs of providing the service, extent of the market accounted for by Medicare, and technological changes not reflected in charges. OBRA instructs the Secretary of Health and Human Services to review payments for 10 of the most costly procedures under Part B. Prevailing charges for cataract surgery were to be reduced in two steps--the first effective January 1, 1987 and the second, January 1, 1988. In an attempt to moderate beneficiary liability, OBRA also limits the actual charges of nonparticipating physicians for a service whose payment rate is lowered under the inherent reasonableness authority.

If Medicare payment for higher priced services (urban, specialist, inpatient, new, and procedural) were lowered, assignment rates and beneficiaries' financial access to these services would probably fall. Similarly, access to lower priced services (rural, generalist, ambulatory, nonprocedural) would most likely rise with increases in their approved charges. The extent of the effect would depend on Medicare's rate compared to that of other payers.

Raising fees in rural areas or lowering urban fees might exacerbate another problem, namely (assignment related) differences in financial access to physician services. As noted above, Medicare assignment rates and participation rates have been positively associated with higher ratios of approved to billed charges. Hence beneficiary access to physician services would be expected to decline in urban areas where Medicare rates relative to private market fees were reduced in the process of reducing urban/rural disparities. Some of the urban areas that already experience above-average charge reductions include New York City, the Washington, D.C. area, and parts of Massachusetts, Pennsylvania, and Michigan (Sisk, et al., 1987). One would expect fewer physicians to agree to participate or to accept assignment in those jurisdictions and other areas that experienced such declines in relative payment levels.

Lowering payment rates for procedures with high fixed costs, such as coronary artery bypass surgery, would stimulate their regionalization, as long as payment levels still covered costs. Regionalization implies fewer total facilities because some providers left or did not enter the market. Of course, volume of services per facility could also increase if physicians induced demand for the procedure, by expanding the range of conditions considered or repeatedly using the procedure (blood chemistries, for example) on a given patient.

The effect of lowering certain approved charges on quality would depend on the appropriate level of specific services, which is often unknown. Lower payment rates for procedural services could improve quality if present rates are unduly stimulating services such as electrocardiograms. Since there is no indication that beneficiaries' health has suffered from lack of access to nonprocedural services, one cannot conclude that changing relative approved charges for procedural and nonprocedural services would improve their well-being.

The effect of lowering rates on Medicare expenditures would depend on changes in volume of services. Changes in beneficiary costs would depend on changes in both service volume and assignment practices. With lower approved charges and no volume changes, beneficiaries net out-of-pocket expenses in the absence of mandatory assignment would most likely increase. Beneficiaries' liability would rise as physicians who did not take assignment billed patients for the previous higher rate, but beneficiaries' coinsurance would fall because of the lower Medicare rates. Physicians would be unlikely to raise their charges to non-Medicare patients. But these physicians would be likely to shift their time and provision of services to other patients for whom physician time was more highly paid. If approved charges were reduced to levels even more below those of the non-Medicare market, more physicians might choose not to participate in the Medicare program.

Reduction of Procedure Codes for Payment Purposes

Several of the 7,040 procedure codes apply to services with minimal distinctions. Office visits have 11 codes, and some particular procedures, such as chest X-ray and colonoscopy, have many categories based on small differences in technology. The multitude of codes permits physicians to bill for the most costly and complex procedures and to bill separately for ancillary services such as routine laboratory tests, which could be included in the office visit charge.

To address these problems, the Omnibus Budget Reconciliation Act requires the Secretary of Health and Human Services by July 1, 1989 to group procedure codes for payment purposes. By January 1, 1990, each Medicare carrier is to make payments on the basis of the new groups. The present situation would be improved if Medicare combined codes that differ in only minor ways, preferably at the carrier level so that physicians could continue to bill with present codes.

If procedure codes were combined, physicians' use of services or total expenditures would probably not increase, especially if physicians used present billing codes. In fact, Quebec's experience in the mid 1970's with combining visit codes and including payment for simple laboratory tests in the office visit rate suggests that such a change would moderate growth in Medicare expenditures for physician services (Barer, et al, 1985). Since payment would be set at the average or mode of previous codes, some physicians and beneficiaries would gain, in greater revenue and lower cost sharing respectively, and others would lose.

Beneficiary Option of Preferred Providers

Giving beneficiaries the option of receiving care from preferred providers would enable Medicare to take advantage of the increasingly competitive marketplace. Medicare could contract either directly with providers or indirectly with preferred provider organizations (PPOs) or insurers for payment below the level of approved charges. Medicare could encourage beneficiaries to use PPO physicians by reducing cost-sharing or premiums. Consistent with the concept of induced demand, physicians joining a PPO might counteract lower Medicare payment rates with greater volume of services. To address this concern, either the PPO or Medicare could undertake utilization control.

In the absence of greater use of services, beneficiaries who used PPO providers would have lower out-of-pocket expenses. Reductions in the deductible or coinsurance rate for using PPO physicians might entice beneficiaries to exercise the PPO option. Many beneficiaries have private supplementary insurance that covers Medicare cost-sharing amounts, but some might welcome the chance not to pay premims for private insurance. Although reducing Medicare premiums would be an attractive financial incentive to beneficiaries, beneficiaries would then be required to receive care only from PPO providers.

Fee Schedules for Specific Services

Since 1984, Medicare has been paying for ambulatory laboratory services according to fee schedules, with assignment mandatory for independent and hospital laboratories. The Consolidated Omnibus Budget Reconciliation Act of 1985 recently extended fee schedule payment and mandatory assignment to clinical laboratory services performed in physicians' offices. Fee schedules could be applied to other specific services to which patients are referred, such as anesthesia services and radiology. Hospitalized patients especially have little role in selecting these physician services. Medicare could also construct fee schedules for expensive sophisticated technologies, such as extracoporeal shock wave lithotripsy and heart transplantation, which are suitable for regionalization, because minimum volumes are needed to maintain skill levels or to spread high fixed costs.

This payment change could be implemented quickly if fee schedules were based on historical average approved charges. Competitive bidding could be used to develop fee schedules for services that are fairly uniform.

With fee schedules, some physicians would receive less and others more than their current approved charge under CPR. Absent other changes, those who received less might reduce their frequency of accepting assignment, in effect, transferring the payment reductions to their Medicare patients. Although mandatory assignment might be proposed to prevent physicians from passing on to beneficiaries the burden of rate reductions, physicians might also attempt to induce demand for their services to recoup lost revenues. Because referral physicians may be less likely to be able to induce demand for their services, such physicians might be the best candidates for initial implementation of a fee schedule with mandatory assignment. (Coincidently, radiologists and pathologists have had relatively high assignment/participation rates (Burney and Schiever, 1985; McMillan, et al., 1985; Unpublished data, Health Care Financing Administration), suggesting a lower probability of reducing assignment or withdrawing from involvement with the Medicare program.

PAYMENT BASED ON FEE SCHEDULES

A fee schedule, in contrast to Medicare CPR payment, pays the same rate for similar services. Medicare has great variation in the fraction of approved charges established at the prevailing charge rate for different services and specialties (Juba, 1987). According to South Carolina data for 1983, for example, the prevailing charge limited payments for about two-thirds of office and hospital visits, but only about one-third of surgical, radiological, pathology, and other medical procedures. For general practice, family practice, and internal medicine, more than 50 percent of approved charges were paid at prevailing levels, with 48 percent for orthopedic surgery. Radiology, general surgery, and ophthalmology were less constrained by prevailing rates.

COBRA and OBRA set in motion the early steps necessary for a Medicare fee schedule for all physician services. By July 1989, the Secretary of Health and Human Services is to develop a relative value scale (a relative weighting) of physician services and to advise Congress about using the scale to construct a fee schedule for implementation by January 1990. OBRA also stipulates that the Secretary shall develop an index to reflect geographic variations in practice costs, collect cost data to refine and update the index, and study the advisability of redefining the localities used for payment.

Paying on the basis of fee schedules would address several of the problems with CPR: variations in approved charges, unpredictability of payment amounts, confusion on the part of beneficiaries and providers, and limited Government control over rising price levels for physician services. Fee schedules could be developed quickly on the basis of the average approved charges that Medicare carriers have historically paid. At that time, rate differentials regarding geography, specialty, and procedural services could be adjusted. Or desired adjustments in relative rates could be made later, as further analysis was performed.

Regardless of how fee schedules were created, they would give Medicare the ability to exert greater control than it has with CPR over the level of and increases in payment rates. A change that reduced the rate of growth in average payment rates would encourage lower costs for individual physician services over time. However, because of the incentives of fee-for-service payment, inefficiencies would be likely to remain in the combination of services and sites of care used for a medical condition.

Conversion to fee schedules would increase payment rates to some physicians and lower them to others, compared to CPR. Physicians who experienced a decrease might attempt to recoup perceived lost revenues by providing or billing for additional services or substituting services with higher approved charges, with no countervailing decreases in service volume by physicians who experienced increases in approved charges. If this occurred, payment by fee schedule might lead to higher Medicare expenditures. For this reason, additional efforts to monitor use and to control unwarranted utilization increases might be necessary. In addition, collapsing procedure codes within a fee schedule could prevent increases in billing for additional services or upgrading of services billed. The experience in Quebec, which collapsed visit codes and incorporated payments for common laboratory tests in the office visit fee, suggests that these changes can check increases in use and total expenditures under a fee schedule (Barer, et al., 1985).

With Medicare fee schedules, there would be much less uncertainty about beneficiary coinsurance liability and physicians' expected Medicare receipts, because Medicare's payment rate could be known in advance for both beneficiaries and physicians. A fee schedule could enable Medicare beneficiaries to become better buyers, because the amount of any unassigned liability would be easier to establish in advance and some beneficiaries would search for physicians who provided a specific service "at the Medicare fee" or request their usual physician to provide the service at that price.

A fee schedule could be used to determine reimbursement in several ways. A fee schedule could serve as a set of maximum allowances, with the approved charge for any service the lower of the physician's billed charge or the fee schedule amount. Under another alternative, mandatory assignment, the approved charge would be deemed payment in full, and physicians would be prohibited from billing above the Medicare allowance. A third alternative would involve Medicare payment of only the fee schedule amount regardless of the physician's actual billed charges. Because beneficiaries would be responsible for paying the difference between the physician's bill and the Medicare allowance, beneficiaries would have a substantial incentive to seek physicians with low charges. Any or all of these alternatives might also be combined with an expenditure cap, which could be implemented by either disallowing claims above the cap or by discounting claims until there was a reasonable expectation that the cap would not be exceeded.

Like fee schedules for specific services, a general fee schedule system would entail paying some physicians more and others less for their services. If a fee schedule system resulted in only small changes in Medicare payment levels, little effect on beneficiary access would be likely. But physicians who faced large declines in Medicare payment rates would be expected to shift their time and services to non-Medicare patients with higher payment rates.

Such physicians would also be less likely to accept assignment and to become participating physicians.

Since no definite relationship has been established between a physician's billed charges and the quality of care provided, one cannot predict how the quality of providers available to beneficiaries would be affected by providers' decisions about accepting assignment and continuing involvement with Medicare under fee schedules. If payment levels were especially low, over time physicians might lower the quality of their supplies, facilities, or personnel. Any changes in relative payment rates to address current urban vs. rural, procedural vs. nonprocedural, specialist vs. generalist, or new vs. established differentials could affect quality, but the direction of the effect is uncertain. For example, lowering rates for previously overused services would improve quality if use became more appropriate, but lowering rates would reduce quality if services needed to maintain or improve health were curtailed. The current dearth of knowledge about the appropriate level of specific services for certain medical conditions makes quality predictions especially hazardous.

PAYMENT FOR PACKAGES OF SERVICES

The concept of payment for packages of related services is that a set prospective payment would put providers at financial risk for the use and cost of those services. The most discussed package for physicians has been for physician inpatient services, to complement Medicare hospital DRG payment, which pays for packages of hospital services.

OBRA instructed the Secretary of Health and Human Services to report to Congress on prospective payment, including information on DRGs, for radiology, anesthesiology, and pathology services to inpatients. In addition, the President's budget for fiscal year 1988 proposed incorporating payment for the inpatient services of hospital-based physicians into Medicare's DRG payments to hospitals (US OMB, 1987). Since physician services to individual patients are excluded from hospital DRGs and paid by CPR-determined charges, neither attending physicians nor hospital administrators have cause to consider the costs of these hospital-based physician services. And inpatients themselves are not in a position to select hospital-based physicians.

If hospital-based physician services were added to hospital DRGs, administrators would encourage attending physicians to use these services more sparingly and to substitute less expensive health professionals where medical conditions allowed, such as nurse anesthetists for anesthesiologists. Hospitals would also wish to contract with hospital-based physicians for services at lower cost. In fact, until passage of a 1982 law, hospitals were able to bill Medicare for both the physician charge and technical cost of pathology and radiology services.

Hospitals in areas with few hospital-based specialists would be in a poor competitive position to negotiate rates and might be unable to keep expenses within the DRG rate. National rates could be adjusted for such local conditions. More difficult to resolve is the antipathy on the part of many hospital-based physicians to control by the hospital. An alternative approach would be to pay hospital-based physicians directly by DRGs. But unlike a hospital, which can spread financial risk over many patients, individual physicians paid for packages of services would be likely to bear a great deal of financial risk for severe or complex cases that required extensive services. Payment by fee schedules would be a more viable alternative.

The quality concern would be that financial constraints would lead physicians to underuse services or provide services of inferior quality. As with any packaging arrangement, acceptance of the Medicare rate as payment in full would be necessary to prevent providers from passing the financial risk to the beneficiaries by billing for amounts over the packaged amount. If case-mix adjustments did not adequately reflect the costs of treating expensive patients, physicians might refuse to treat such patients and to shift their practice to other sites and to non-Medicare patients. However, Medicare has substantial leverage over hospital-based specialists, since it accounts on average for from 21 percent to 28 percent of their gross practice income (Owens, 1983). And radiologists and pathologists have historically had higher than average assignment rates (US Congress, 1983).

Whether Medicare's expenditures were moderated would depend on the extent to which physicians were able to shift services outside the package to ambulatory sites. If the packaged rate was set at the current mean, the coinsurance of some beneficiaries would rise while others fell. Overall, beneficiaries' out-of-pocket expenses could rise if physicians shifted care outside the package.

Given the lack of experience with packaged payment for physician services, a demonstration project might be more appropriate than an immediate change in the law. Such a demonstration might be acceptable to physicians if Medicare paid 100 percent of the packaged rate, reducing the risk of bad debts from the beneficiary copayment.

CAPITATION PAYMENT

Since February 1985, beneficiaries have been able to elect that Medicare pay for their medical care by capitation, a monthly payment set in advance and independent of the services actually used. With capitation, the financial risk of covered services is borne by the payment recipient, instead of Medicare and the beneficiary. Enrollment in risk-sharing plans as an alternative to CPR payment has grown dramatically and by March 1987 encompassed close to 900,000 beneficiaries, about 3 percent of the total (US Senate Aging, 1987). Medicare capitation payment to risk-sharing plans is therefore a recent innovation that is still being adopted and whose implications are still unclear.

Proposals to expand capitation would broaden the definition of risk-sharing plans or would pay a fiscal agent to assume the financial risk for the medical care of beneficiaries in a geographic area. An alternative not being seriously advanced is mandatory capitation payment, which would require beneficiaries to select plans. All capitation proposals include an option for beneficiaries to continue having current coverage and obtaining individual services on a fee-for-service basis.

Since capitation payment provides no extra revenue for extra services, recipients have an incentive to use the most efficient number and mix of services for a patient's condition. But the incentive is also against providing additional services, as long as patients do not become dissatisfied and disenroll. Paying a plan or fiscal agent buffers these incentives on physicians, who in turn may be paid by capitation or a share in a risk pool, fees for services, or salary.

Expansion of Voluntary Capitation

Medicare may now contract with federally qualified health maintenance organizations (HMOs) and competitive medical plans (CMPs) on a capitation basis. Medicare's payment is limited to 95 percent of the estimated average per capita cost (AAPCC) of care for beneficiaries in an area who are not enrolled in plans; the AAPCC is adjusted for age, sex, disability, welfare and institutional status of beneficiaries. Risk-sharing plans must provide Medicare's covered benefits and limit beneficiaries' premiums and cost-sharing to the actuarilly equivalent amounts that non-enrollees would pay under Medicare (the adjusted community rate). HMOs and CMPs face the same general requirements for their Medicare business, but HMOs are subject to additional restrictions for other enrollees.

The Administration and legislation introduced in December 1985 (S.1985) would broaden the definition of eligible plans from risk-sharing HMOs and CMPs to include those set up by insurance companies and by employers. In exchange for a fixed capitation payment, risk-sharing plans, termed health benefit organizations, would be required to provide or arrange for beneficiaries' covered care, but they would be relieved of certain requirements that now apply to HMOs and CMPs. Health benefit organizations would not have to increase benefits or return funds if the capitation payment exceeds the premium that the plan would have charged non-Medicare enrollees for the same coverage. Nor would health benefit organizations be subject to requirements for quality assurance activities that previous legislation has applied to HMOs and CMPs, although the Secretary of Health and Human Services would have the right to evaluate the quality of services provided. In addition to the legislative proposals, the Health Care Financing Administration (HCFA) is planning demonstration projects for beneficiaries to enroll in risk-sharing plans sponsored by employers.

Easing requirements for plans to contract with Medicare would most likely lead to greater beneficiary enrollment because of expanded options. Through health benefit organizatons, employers and insurers might offer benefits supplementary to Medicare, thereby permitting a beneficiary to deal with one agent for coverage and simplifying administration for the beneficiary and the employer or insurer.

There is only limited information from which to predict the effect on quality of care from either greater enrollment in HMOs and CMPs or from broadening the concept of risk-sharing plans. Studies of HMO enrollees have generally found quality equal to or better than that provided by comparison groups in the fee-for-service sector (Cunningham and Williamson, 1980; Luft, 1981), but several grounds for caution remain. One is that the financial incentives of capitation payment may encourage plans not merely to use services judiciously, but also to underprovide services. Although this problem has not characterized the large, established prepaid group practices that have been studied, these practices may differ greatly from newer HMOs, which tend to be smaller, operated for profit, and organized as individual practice associations (IPAs) (InterStudy, 1985). Tenuous arrangements between the parent HMO and certain provider groups may partly explain difficulties that beneficiaries experienced at a large HMO in Florida (US Congress, GAO, 1986). Furthermore, past studies have not looked at the care of elderly people, who may have multiple conditions that require special care and impairments that make obtaining care more difficult (Hammons, et al., 1986). In addition, recent findings raise particular concern about the ability of low income people to cope with a large health care organization. Low income people with medical problems who were enrolled in a prepaid group practice and had no outreach program had worse health outcomes than comparable fee-for-service patients (Ware, et al., 1986).

A HCFA-funded evaluation of quality of care in risk-sharing demonstration projects is scheduled for completion this year (Rossiter, et al., 1985). In addition, HCFA has implemented provisions of OBRA, which addressed concern about the quality of beneficiaries' care by requiring review of services provided by HMOs and CMPs.

Compared to beneficiaries in the CPR system, those in risk-sharing plans have often improved their financial access to care, because plans have reduced cost sharing or added benefits when Medicare's capitation payment exceeded the premium that the plan would have charged non-Medicare enrollees for the same coverage. Competition for enrollees might spur plans to pass on to beneficiaries the same level of benefits if federal requirements about premiums and cost sharing were removed. There is some evidence that Florida plans have competed for enrollment by decreasing cost sharing.

The effect of risk-sharing arrangements on Medicare program expenditures is less clear. Prepaid group practices have delivered care at lower total cost than fee-for-service comparison plans (Luft, 1981; Manning, et al., 1984). But Medicare may not be reaping these benefits because the technology of adjusting capitation rates to the likely costliness of a beneficiary's care is poorly developed. Both Medicare and risk-sharing plans are at substantial financial risk because of the variation among beneficiaries in Medicare payments. In 1982, only 5 percent of beneficiaries accounted for 54 percent of Medicare payments, but no payments were made for 39 percent of the beneficiaries (Riley, et al., 1986). Some studies have suggested that Medicare prepaid group enrollees have had lower expenditures than other beneficiaries even before enrollment (Beebe, et al., 1985; eggers and Prihoda, 1982). If Medicare pays 95 percent of the AAPCC for beneficiaries whose costs are much lower than average while high-cost ones remain in the CPR sector, Medicare expenditures could even rise. Payment rates that are not properly adjusted for risk may also give plans an incentive to try to attract low-risk enrollees and discourage high-risk ones. In recognition of problems with existing capitation rates, OBRA stipulates that the Secretary of Health and Human Services study methods to refine capitation rates and submit legislative recommendations to Congress by January 1, 1988.

A risk-sharing plan is more likely to "buy" the services of expensive new technology from outside the plan and to delay "making" the services internally until higher use rates spread high fixed costs over a greater volume of services. Kaiser-Permanente in Northern California has applied this approach to the adoption of open-heart surgery and X-ray computed tomography. Scrutinizing new technology carefully and adopting it only when its effectiveness is clear are certainly desirable. Although there is no evidence that HMOs have been less likely to use expensive technologies, new plans might behave differently, especially if procedures such as organ transplants and articifical organs proliferate. As enrollment in risk-sharing plans grows, independent evaluation of new technologies, now performed for Medicare by the Public Health Service, will therefore continue to be important to safeguard beneficiaries' entitlement to up-to-date medical care.

Geographic Capitation Payment

Medicare has received applications for demonstration projects to test geographic capitation. In exchange for capitation payments, a fiscal agent (a Medicare carrier, utilization and quality control peer review organization ([illegible]), or other entity) would assume the financial risk for the covered services of all the beneficiaries in an area. The fiscal agent would negotiate with local physicians and other providers and plans. Beneficiaries would then choose among plans, with continuation of the of fee-for-service physicians and present Medicare benefits and cost sharing as one option.

Geographic capitation would give Medicare much greater control over program expenditures. Beneficiaries could also gain, if plans competed for enrollees by reducing cost sharing or adding benefits. This variation of capitation payment would reduce the importance of establishing rates for different risk categories of beneficiaries, because the risk would be spread over all the beneficiaries in a large area. Demonstration projects could test different formulas for Medicare to share unusual expenses with the fiscal agent.

A disadvantage is that substantial market power would be concentrated in the fisal agent. Prohibiting the fiscal agent from sponsoring plans would help to prevent this situation. Even if the fiscal agent did sponsor plans, such as an HMO and PPO, requiring an open enrollment period for all plans could foster more competition.

Since this payment arrangement has not been tried, demonstrations would be vital to evaluate the effects on quality and access. This aspect of the demonstration would be especially important because both the fiscal agents and the plans would wish to control use and cost and might do so at the expense of quality and access.

POLICY IMPLICATIONS

Congress could implement several physician payment reforms in a fairly short time. Recent legislation has already required the Secretary of Health and Human Services to reduce the number of billing codes and to review payment rates for costly procedures. Other options that entail the least change from present CPR payment or that call for research and demonstrations could be undertaken within 1 or 2 years. With legislative changes or as a demonstration project, Medicare could move quickly to give beneficiaries financial incentives to receive care from "preferred providers" who agreed to accept payment below the level of approved charges. Creating fee schedules from carrier data on physician charges is another viable short-term option.

Options that depend on further analysis, especially regarding resource costs and relative value scales, would require a longer period of time to carry out. Congress could implement capitation payment for all beneficiaries quickly using present payment rates based on the AAPCC or delay changes until payment rates are more refined and recent demonstration projects have been evaluated. For the most part, payment for packages of services, as opposed to research or demonstrations on packaging, is not ready to be implemented because payment categories have not been developed or tested.

With any payment method that pays fees for services, concern will continue that providers will increase their volume of services if payment rates are limited. Since details of 1987 Part B expenditure are not yet available, it has not been possible to separate increases in volume generated by providers from other phenomena. Researchers have observed that the portion of beneficiaries receiving physician services paid by Medicare rose from 67 percent in 1981 to 75 percent in 1986 (McMenamin, 1987), but the causes of those increases and their relationship to 1987 increases remain to be determined.

Implicit in all proposed payment reforms is the intention to reduce the growth, and sometimes the absolute level, of Medicare payment rates. In some cases, improved quality or access may result. Greater regionalization of expensive facilities and procedures, for example, may increase volume and reduce complication rates, and lower inpatient surgical rates may reduce nosocomial infections. HMO enrollees are likely to have greater financial access to care because of lower cost sharing at the time of use.

The danger is that constraining program expenditures may impair access to and quality of care for beneficiaries, especially for poor or infirm people, who are more vulnerable. With fee schedules and continuation of voluntary assignment, beneficiaries' out-of-pocket expenses might rise (and their financial access decline) as higher-cost physicians billed their usual rate. With mandatory assignment under fee schedules or diagnosis-related groups for physicians, physicians with higher fees might refuse to take Medicare patients. Risk-sharing plans may try to avoid enrolling people at high risk of expensive care if present inadequacies in rate-setting techniques continue, and enrollees in general may have difficulty dealing with a large bureaucracy.

With constraints in payment rates, concerns about quality would arise mainly about substandard facilities or providers and underuse of services. Assessing and assuring quality are particularly difficult tasks because the appropriate level of use is unknown for many, if not most, services. The difficulty is intensified with Medicare payment reforms because quality review and assurance have historically related to excessive rather than insufficient use of services.

With any payment reform, it will thus be incumbent on the program to monitor providers' willingness to accept Medicare patients and payment rates across services, specialties, and localities and to take corrective action if problems arise. Moreover, careful attention to the level and structure of payment rates may avoid many access problems. More than monitoring will be necessary to safeguard beneficiaries' quality of care. Informed evaluation also requires prior research on the appropriate use of services.

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ITEM 5

Statement of the Physician Payment Review Commission

Philip R. Lee, M.D.
Chairman

November 2, 1987

The enormous premium increase that has been announced for Medicare Part B is the latest manifestation of long-term trends of rapidly increasing outlays in this program. These increases, which are far in excess of the rate of inflation, have imposed substantial burdens on both Medicare beneficiaries and the nation's taxpayers, who now foot 25 percent and 75 percent respectively of the federal bill for this program. The Physician Payment Review Commission has serious concerns about these trends, and is working to develop carefully considered options to recommend to the Congress.

TRENDS IN OUTLAYS FOR PART B

At the last meeting of the Commission, its staff presented data on trends in Part B outlays over the 1975-1985 period. Of the 16 percent per year average annual increase, increasing numbers of enrollees accounted for 2 percentage points, higher prices accounted for 7 percentage points, and more services per enrollee accounted for 7 percentage points. Over the ten-year period, services per enrollee almost doubled. Recent trends show a changing mix of Part B reimbursement, in both type and location of service. Specifically, utilization of non-physician services (e.g., diagnostic tests, equipment and supplies) has increased more rapidly than the use of physician services. Further, the mix of physician services has also changed, with a growth in expenditures for surgical as opposed to medical services. Coupled with these changes, we have also seen a shift in the location of services from inpatient to outpatient and office settings.

It is too early to know whether the data reported for 1986 and 1987 indicate an acceleration of the growth in services per enrollee. At a minimum, the data indicate that past years' high rates of growth are continuing. These data and the associated premium increase reinforce our conviction that we must consider how to address the growth of volume in medical services, while keeping in mind the changing nature of the medical care provided through Part B.

As we review the data before us and consider options that affect the utilization of services, we must be cautious about the interpretation of the increases we see. There are multiple factors affecting the quantity of services provided. Some of the increase in services reflects a reduction in unmet needs or new or improved capabilities to provide needed care. Some is the result of policies adopted deliberately to improve access to care (e.g., incentives for physicians to become participating physicians). But some undoubtedly reflects an increase in services that do not help patients significantly. It will be difficult to distinguish between volume increases resulting from the provision of important additional services to patients and those reflecting services of little or no value to patients.

Both physicians and beneficiaries play important roles in determining the volume of medical services provided. Physicians, as agents of their patients, render professional judgments regarding the use of medical services, including their own services. They are expected to provide all services of benefit to their patients. But, physicians also have a financial incentive to provide more of all services. The potential for physicians to adjust the number and mix of services they provide in response to such an incentive has led to concern. There is some evidence in the research literature that physicians have responded to fee constraints by providing additional services. Some of the increase in utilization we are now trying to explain may reflect physicians' response to recent increased economic pressures on their practices. The 1984 freeze in physician fees, the continuing effects of the Medicare Economic Index (MEI) in constraining prevailing charges and the introduction of the Maximum Allowable Actual Charge (MAAC) to restrict increases in actual charges for physicians who do not accept assignment are all examples of policies that have contributed to a changing economic environment for physicians.

The increase in physician supply, particularly in the past ten years, would have been expected to increase the quantity of services provided simply as a result of its improving the availability of services. Since the growth in the number of physicians per capita also results in smaller patient loads on average, however, the question arises as to whether physicians may have responded to increased competition for patients, in part, by increasing the number of services per patient.

In some cases, what appears in the data as increased utilization of services by Medicare beneficiaries may in fact result from changes in the ways physicians bill for services. Billing separately for services that previously had been billed as part of a single package (e.g., office laboratory tests associated with an office visit, such as urinalysis or test for occult blood) will appear to increase the quantity of services provided. While the actual quantity of services may remain unchanged, such "unbundling" of services often leads to higher expenditures, because the sum of the payments for the individual services may amount to more than the single payment for the service package. Both the reporting of services and expenditures can be affected as well by "upcoding." Where coding systems present a range of services that may be close substitutes, physicians have incentives either to bill under the code that generates the highest approved charge or to provide more complex (and more expensive) services than they would otherwise have considered appropriate treatment.

Beneficiary demand for care also has contributed to the increased use of services. Access to physicians probably has improved with the increase in physician supply, making it easier for beneficiaries to obtain physician services. Moreover, financial barriers to care may have been reduced in recent years through the combined effects of the freeze on physician fees and increases in assignment rates.

Increased media coverage of advances in medical technology and procedures also may encourage patients to demand more care from their physicians. Consumer awareness of the technology available to detect and remove malignant lesions in the colon provides the most likely explanation for the 50 percent increase in the number of colonoscopies in the period immediately following President Reagan's well-publicized surgery.[1]

Beneficiaries seek the services they think will meet their medical needs. Their demand will be tempered by out-of-pocket costs associated with that care. Medicare and supplementary coverage, however, insulate them from much of the cost of the services they receive. Decisions about the use of any service that is perceived to have some potential benefit, thus, will be influenced not only by the positive financial incentive to physicians to provide the service but by the weak financial incentive for beneficiaries to restrict their use of services.

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[1] Preliminary results from a study by Peter McMenamin and Howard West of Circle, Inc., reported in the American Medical News, September 18, 1987.

Among the factors often suggested to explain the increase in use of services by Medicare beneficiaries is the aging of the population. Not only is the elderly population growing, but the elderly as a group are aging. While the growth in the elderly population contributes to growth in Part B outlays to some extent, the aging of the elderly population has only a minor effect on the growth in services per enrollee. The older elderly do use services at a higher rate than Medicare enrollees in general, but the Medicare population is not aging rapidly enough to make a major contribution to the nearly 7 percent annual increare in services per enrollee.[3]

Changes in medical technology lead to changes in the practice of medicine that have implications for the numbers and types of services provided under Part B of Medicare. New equipment or techniques enhance physicians' ability to respond to the medical needs of the elderly population. Advances in medical technology can affect utilization either by adding new services and equipment or by substituting for other services. Innovations that reduce risk, discomfort, and inconvenience for the patient are likely to be used more frequently than their predecessors. Moreover, refinements in technology may lead to more specialized applications that increase the overall number of procedures performed for a given condition.

Advances in both surgical techniques and anesthesia have made it possible to move procedures traditionally performed in the hospital to outpatient sites. Medicare prospective payment for inpatient hospital services also has moved some services previously performed while patients were hospitalized to outpatient settings because of the incentives for preadmission testing and earlier discharge of hospital patients. As noted earlier, these shifts from inpatient to outpatient care are reflected in increased service volume and increased expenditures under Part B of Medicare. The shift is less relevant for physician services than for nonphysician services covered under Part B, such as hospital outpatient departments and durable medical equipment, since physician services within the hospital have always been covered under Part B. While the movement of hospital services to outpatient settings has led to increases in Part B expenditures, it has probably reduced overall Medicare costs. But it also has shifted costs to beneficiaries, including costs for some services covered only as inpatient services (e.g., prescription drugs), increased copayments, and increased premium costs required to cover 25 percent of Part B program expenditures.

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[3] The number of SMI enrollees is growing about 2 percent per year. Our calculations indicate that the aging of this population contributes only 0.1 percent per year to growth in SMI outlays.

WORK OF THE COMMISSION

In its work to reform physician payment in the Medicare program, the Commission has followed two tracks. One has focused on the pattern of relative payments for physicians' services. The current pattern of variation in payment among services and among geographic areas is not a rational one.[3] It gives distorted signals to physicians concerning how to practice, what specialty to train for, and where to locate. The pattern of payment also creates inequities among physicians and the beneficiaries they serve. To deal with these problems in pricing of physicians' services, the Commission is in the process of developing a fee schedule, and has recommended to this Committee that interim changes in Medicare physician payment alter relative prices towards the pattern likely to be adopted as part of a fee schedule.[4]

The Commission anticipates that adoption of a fee schedule would slow the rising volume of physician services through more appropriate incentives. Reducing fees that are too high will diminish the financial incentive to provide too many of these services. However, a fee schedule alone would not be sufficient to contain costs as much as needed. We have only limited information with which to predict the degree to which the use of individual services would respond to changes in relative prices. We do not know whether the savings from reduced use of those services whose relative values are lowered would be offset by increased use of those services whose relative values have increased. In addition, fee schedules keep intact fee-for-service incentives in which doing more for patients enhances the income of the provider.

For this reason, the Commission is pursuing a second track concerning policies to contain increases in the volume of services per enrollee. While planned from the beginning, this work began in earnest over the summer, and a substantial portion of the Commission's agenda will be devoted to it for the foreseeable future.

The importance of this work has been underscored by your health subcommittee. In May of this year, Congressmen Stark and Gradison asked us to put a top priority on policies to control the rapid growth in the use of physician services. They also noted that it is a "tall order" to come up with effective policies that neither threaten financial protection for Medicare beneficiaries nor compromise their access to needed health care.

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[3] The Commission's first annual report to Congress in March, 1987, is a source of additional information on the problems of the current system of payment and options for reform: Physician Payment Review Commission, *Medicare Physician Payment: An Agenda for Reform*, Government Printing Office, Washington, DC, March 1987.

[4] Statement of Philip R. Lee, M.D., Chairman, Physician Payment Review Commission, before the Subcommittee on Health, Committee on Ways and Means, June 15, 1987.

To begin its work on the volume of services, the Commission has solicited the advice of medical organizations, consumer groups, and others. The initial response has been constructive and encouraging. We will also draw upon the work of several agencies of the government, including the Health Care Financing Administration (HCFA), the General Accounting Office (GAO), and the Office of the Inspector General (IG).

The need to slow the increase in the costs of the Medicare program is critical. Nevertheless, despite the importance of the need to contain costs, the Commission will not recommend solutions that would cause undue hardship for beneficiaries. Medicare was created to provide access to good quality health care to its beneficiaries, and to cushion the financial consequences of ill health. As the Commission stated in its first report to Congress, these objectives should not be sacrificed.

POLICY DIRECTIONS

The task, then, is to reduce costs without inadvertently compromising access and quality of care. This will require that physicians and beneficiaries selectively reduce those services that are least important to patients' health. The policy options that the Commission will consider offer several different mechanisms aimed at encouraging beneficiaries to demand and physicians to provide only services that are of significant medical benefit. These options range from physician education, to utilization review, to the use of financial incentives. It is likely that a combination of these options will be required.

The success of these efforts will depend on the ability to distinguish services that improve patient outcomes from those that provide little or no medical benefit (or even risk harm to the patient). To do this, both physicians and beneficiaries will need better information on the effectiveness of medical services.[5]

There are large gaps in our knowledge of the effectiveness of medical services, and of the best ways to care for patients. Only limited resources have been devoted to research on determinants of patient outcomes and costs of care. While additional clinical research is needed, much more could be done within the limits of current medical knowledge. Studies have shown that there is considerable variation in medical practice across geographic areas, across delivery systems, and across individual physicians. They suggest the provision of substantial amounts of unnecessary services. They lead us to believe that there is considerable potential for reducing the use of unnecessary services without compromising the quality of care. Involvement of the medical community is critical for success of this effort.

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[5] Physicians and patients jointly determine what services are used in the patients' care. Since physicians usually have a better understanding of the effectiveness of services, they often play the greater role in the selection of services. This discussion is focused more on improving information available to the physician, but applies to both physician and patient.

Recent work demonstrates how physicians can develop guidelines for appropriate use of services and optimal care of patients. For example, the American College of Physicians and the Blue Cross and Blue Shield Association have cooperated in the development of guidelines for the use of common diagnostic tests. The American College of Physicians, through its Clinical Efficacy Assessment Project, has developed guidelines for appropriate use of services, such as endoscopy in patients with dyspepsia, and appropriate care of patients with selected conditions including cholecystitis and diabetes. The Health Services Utilization Study by the RAND Corporation has used expert consensus to develop appropriate indications for use of coronary angiography, upper GI endoscopy, and carotid endarterectomy. The American Medical Association's Diagnostic and Therapeutic Technology Assessment (DATTA) project uses panels of expert physicians to address questions of safety and efficacy of medical technologies.

Such programs can develop sound, practical, and credible standards or guidelines based on the consensus of medical experts after thorough review of available medical literature. These guidelines for appropriate use of services can provide the basis for both programs to educate physicians and beneficiaries and for utilization review activities. With additional resources, this process could be used to develop guidelines for other procedures and for care of a greater variety of patient problems. This process is not without cost. However, investment of a small fraction of the annual expenditures for Medicare could yield substantial returns in more cost-effective care.[6]

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[6] The clinical research described here has been carried out by several investigators. Some has been sponsored by professional societies. It has been supported by a variety of sources including the National Center for Health Services Research and Health Care Technology Assessment, the Health Care Financing Administration, the Blue Cross Association, and several private foundations.

With more information about which services really improve patients' outcomes, physicians and beneficiaries will be in a better position to judge the merits of services, particularly those that now fall into a grey area--their medical value is uncertain but probably very small. Given fee-for-service incentives that encourage the physician to do all that might benefit the patient and fears of malpractice suits, better information on what services are of little or no benefit will need to be in the physician's hands if services in this grey area are to be significantly reduced.

Physician Education

Information cannot be expected to affect the provision of services unless it is systematically disseminated to physicians. Many in the physician community believe that most physicians will alter their practices if they are informed that their practices do not conform to standards developed by expert physicians in their own field of medicine. Information on appropriate use of services can be made available to physicians through educational programs that emphasize expert standards for care, such as those developed by the American College of Physicians and the Blue Cross and Blue Shield Association, or provide physicians with direct comparisons of their practice patterns with those of their peers.

One example of the latter type of program is the Maine Medical Society's sponsorship of the Maine Medical Assessment Project to inform physicians how their use of specific services compares with their peers in the state. This appears to have led to reductions the targeted services in areas of high use.

The Commission is reviewing examples of programs to educate physicians and beneficiaries using specific guidelines for appropriate care, such as those for common diagnostic tests and endoscopy. It will assess the potential of these programs to improve the cost effectiveness of care provided to Medicare beneficiaries.

Utilization and Quality Review

Review of utilization of services is performed by Medicare carriers and by Peer Review Organizations (PROs). The review of utilization is based on rules that are intended to identify unnecessary services and either dissuade the physician from providing them or deny payment for them. PROs have also begun to evaluate quality of care.

The Commission has begun to study programs of utilization and quality review used by carriers, PROs, and the private sector. Drawing on studies by HCFA, GAO, and the HHS Inspector General, we will examine alternative mechanisms to improve the effectiveness of carrier and PRO medical review. For instance, how cost effective are the utilization and quality screens used to select cases for physician review? PROs now focus on inpatient care, though a substantial amount of care has shifted from the hospital to outpatient settings, where there is less review of use of services and their quality. We will consider whether PRO or similar review should be expanded to incorporate care in outpatient settings.

We are particularly interested in how well these programs incorporate current medical knowledge of the appropriateness of services. Utilization screens and conditions for prior approval of admission or a procedure would be more easily accepted if they were based on credible standards developed by peers. For example, a physician's reason for doing a planned coronary angiography could be compared to accepted indications for that procedure developed through expert consensus.[7]

Financial Incentives

The Commission also plans to consider various methods that emphasize the use of financial incentives to physicians and patients. For physicians, these range from mechanisms that alter the incentives of individual physicians to prescribe services to those encouraging broad groups of physicians to practice in a less-costly style. An example of the former approach is increased use of procedure packaging. Traditionally, surgery has been paid for on the basis of a global fee--a fee that encompasses the major surgical procedure, ancillary procedures by the surgeon, and post-operative visits by the surgeon. The global fee approach could be extended to non-surgical procedures by including the associated office or hospital visit with procedures such as colonoscopies.

Physicians charge for a number of services that they do not personally perform, such as diagnostic tests. If the physician is allowed to charge the patient more than the cost of the test, there is a financial incentive to order such tests. Congress has attempted to limit this practice for clinical laboratory tests. The Commission will examine whether this approach should be extended to similar services.

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[7] Such guidelines or standards must be applied thoughtfully and flexibly. No set of standards can specify exactly what should be done for every patient. Their application must take account of variations in the clinical situation. Rigid application of guidelines, such as using them as ceilings on services deemed to be appropriate for all patients in a category, could reduce the quality of care and will compromise the effectiveness of the utilization program itself.

At the opposite end of the spectrum, Medicare allowed fees in an area could be based in part on the use of services by all physicians in the area. For instance, the prevailing charge for each service could be reduced if total expenditures in the area exceeded a budget target, or increased if expenditures were below a target. A policy of this type has been is used in West Germany. While it would not appreciably alter financial incentives to individual physicians, it could encourage more vigorous actions on the part of the physician community to support peer review activities and educate their members on appropriate medical practice.

The Commission will also examine the effectiveness of financial incentives for beneficiary use of services. For instance, do copayments selectively reduce the use of unnecessary services, or do they reduce access to needed services?

Capitation

Since Congress made a key decision in 1982 to authorize Medicare to offer a more attractive risk contract to HMOs, capitation has become an option for a significant number of beneficiaries. The research literature indicates that HMOs can reduce the use of services, especially hospital services, by a substantial amount. The Commission has begun to examine a number of issues pertaining to capitation by HMOs in Medicare. It plans to look into revising the method by which capitation payments are calculated. It will study the appropriateness of policies by HMOs to limit use of services by enrollees, including certain types of incentive contracts between HMOs and physicians. It will assess whether the definition of a "qualified" health plan should be changed.

The ultimate role that capitation will play in the Medicare program is not yet known. Policy decisions that are made now will have some bearing, but the ability of HMOs and other private health plans to contain costs, and the acceptability of these plans to Medicare beneficiaries, will be the key considerations.

Billing Practices

Evidence of changes in billing practices by physicians that contribute to increases in Medicare outlays is mostly anecdotal, but prudent management requires substantial efforts to uncover and prevent improper billing practices.

Many physicians have expressed to the Commission their concerns about billing practices of some of their peers. Part of the Commission's work to develop a fee schedule concerns the coding of medical procedures for payment purposes. For example, the Commission is testing the use of consensus panels to consider whether closely-related services should be paid the same amount and to clarify and standardize definitions of what is included in surgical global fees. This could facilitate carrier review activities.

Physician Supply and Tort Reform

A part of the solution to rising outlays for physicians' services may lie outside of reform in payment methods. While beyond the Commission's mandate, policies concerning physician supply and medical malpractice could well be part of the solution to the problem of containing the costs of physicians' services.

CONCLUSION

Medicare has provided the elderly and the disabled access to medical care of high quality while protecting them from financial hardship. Continued rapid increases in the volume of services are making this accomplishment increasingly difficult for beneficiaries and taxpayers to underwrite. Given the evidence that some of these services have little medical benefit to the patient, we can contain costs without sacrificing the goals of Medicare by designing policies that will inform physicians and patients which services these are and induce them to forego them. This will not be an easy task, but one that must be done.

ITEM 6

AARP

November 18, 1987

The Honorable John Melcher
Chairman, Senate Special Committee on Aging
U.S. Senate
Washington. D.C. 20510

Dear Mr. Chairman:

On November 2, 1987, the American Association of Retired Persons (AARP) testified before your committee concerning the Part B premium increase for 1988.

At that time we testified that approximately 742,000 beneficiaries would not receive a Social Security cost-of-living-adjustment (COLA) because of the size of the scheduled premium increase.

We have recently refined our estimates. After taking into account the manner in which the Social Security Administration is required to round beneficiaries' checks under Sections 215(g) and 1839(c) of the Social Security Act, it appears that an additional 878,800 beneficiaries will also not receive a COLA. This brings the total number of beneficiaries not receiving a COLA to about 1.6 million in 1988.

Attached is a chart detailing this information. If the hearing record is still open we would appreciate the inclusion of this revised data.

Thank you for your attention to this important issue.

Sincerely,

Martin A. Corry
Director, Federal Affairs

American Association of Retired Persons 1909 K Street, N.W., Washington, D.C. 20049 (202) 872-4700
John T. Denning *President* Jack Carlson *Executive Director*

COST OF INCREASED MEDICARE PART B PREMIUM, 1988
NUMBER OF BENEFICIARIES NOT RECEIVING COLA

SMI ENROLLEES	AVERAGE MONTHLY SOC SEC	4.2% COLA	TOTAL BENEFIT ROUNDED	PART B PREMIUM INCREASE	BENEFIT CHANGE	TOTAL COST
2,900	$5.00	$0.21	$5.20	$6.90	-$6.00	$19,430
3,800	$15.00	$0.63	$15.60	$6.90	-$7.00	$23,940
4,300	$25.00	$1.05	$26.00	$6.90	-$6.00	$25,370
7,500	$35.00	$1.47	$36.40	$6.90	-$6.00	$41,250
9,700	$45.00	$1.89	$46.80	$6.90	-$6.00	$49,470
15,300	$55.00	$2.31	$57.30	$6.90	-$5.00	$70,380
15,700	$65.00	$2.73	$67.70	$6.90	-$5.00	$65,940
44,300	$75.00	$3.15	$78.10	$6.90	-$4.00	$168,340
43,900	$86.00	$3.61	$89.60	$6.90	-$4.00	$144,870
45,900	$96.00	$4.03	$100.00	$6.90	-$3.00	$133,110
59,400	$106.00	$4.45	$110.40	$6.90	-$3.00	$148,500
54,000	$116.00	$4.87	$120.80	$6.90	-$3.00	$113,400
85,800	$126.00	$5.29	$131.20	$6.90	-$2.00	$145,860
117,200	$136.00	$5.71	$141.70	$6.90	-$2.00	$140,640
116,400	$146.00	$6.13	$152.10	$6.90	-$1.00	$93,120
116,200	$157.00	$6.59	$163.50	$6.90	-$1.00	$46,480
282,700	$167.00	$7.01	$174.00	$6.90	$0.00	$0
234,900	$177.00	$7.43	$184.40	$6.90	$0.00	$0
361,200	$187.00	$7.85	$194.80	$6.90	$0.00	$0
324,000	$197.00	$8.27	$205.20	$6.90	$1.00	$0
717,500	$207.00	$8.69	$215.60	$6.90	$1.00	$0
315,000	$217.00	$9.11	$226.10	$6.90	$2.00	$0
376,800	$227.00	$9.53	$236.50	$6.90	$2.00	$0
419,300	$238.00	$10.00	$247.90	$6.90	$3.00	$0
459,700	$248.00	$10.42	$258.40	$6.90	$3.00	$0
....	....					

PERSONS W/ NO COLA	MONTHLY COST	$1,430,100
1,621,100	ANNUAL COST	$17,161,200

ITEM 7

The University of Arizona
Health Sciences Center
Department of Internal Medicine
Section of Cardiology
Tucson, Arizona 85724
(602) 626-6221

Special Committee on Aging
United States Senate
Dirksen Building
Washington, D.C. 20510

Sirs:

This statement comes from a group of physicians who have been studying the Medicare professional fee schedule to determine what procedures are being inappropriately rewarded and how funds can be saved by adjustment of such fees.

I am the chairman of this committee (The Independent Study Group). I am Clinical Professor of Medicine in the Section of Cardiology at the University of Arizona Medical Center. Previously I have appeared as a witness at the hearings on waste, fraud and abuse in the pacemaker industry held by the Committee, and I have served as a consultant to the FBI personnel who have been seconded to Medicare for the investigation of health-related frauds.

Respectfully submitted

Brendan Phibbs, M.D.

STATEMENT
# of the
INDEPENDENT PHYSICIAN"S STUDY GROUP
before the
SPECIAL COMMITTEE ON AGING
# of the
UNITED STATES SENATE.

POTENTIAL MEDICARE SAVINGS BY ADJUSTMENT OF EXCESSIVE PROFESSIONAL FEES.

An independent committee of physicians has been investigating the appropriateness of the professional fees paid by Medicare. The study is not complete, but some conclusions are already obvious.

1. Some professional fees paid by Medicare are excessive.

2. The total of these excessive payments amounts to a very large sum: study of only four specific categories of payment reveals potential savings of over half a billion dollars annually if a rational fee schedule were instituted.

3. In some cases these excessive fees are simply anachronistic: as a result of advances in medical technology some procedures can be performed easily and quickly, but the fees have remained fixed at levels set when the same procedures were difficult and prolonged.

4. In other categories, high fees were set simply because a procedure was new, experience was limited, and physicians were only beginning to acquire the requisite skills. Now that the procedures are commonplace, the fees should be adjusted to equate with comparable categories of professional performance. Instead, the inappropriate high fees have persisted: a kind of "cultural-professional lag" has prevented rational change.

5. Financial rewards for hospital-based physicians, included in Medicare hospital payments, have been excessive, because of the same kind of lag. There was a time when anesthesiologists, pathologists, and radiologists were in short supply, and the professional fees in these categories were correspondingly high.

The shortage has been corrected: anesthesiologists and radiologists are present in adequate numbers and pathologists are redundant. Pathologist's salaries have in many areas fallen to a reasonable level in comparison with such underpaid performers as pediatricians and internists, but the other two categories still command inappropriately large rewards, completely out of keeping with years of training, difficulty of performance, or supply of physicians.

METHOD OF STUDY.

The Study Group has used a simple comparison method to begin analysing appropriateness of fees.

The fee paid for cholecesytectomy- removal of the gall-bladder- was determined in as many Medicare areas as possible. It was found to be consistently close to 750.00

Three factors enter into this fee.

A. To qualify to perform this or other major abdominal surgery a physician must fulfill five post-graduate years of training in an approved surgical program.

B. The procedure itself requires one to two hours: it should be classed as a highly skilled procedure with substantial risk.

C. Three days of postoperative care will be required, sometimes intensive.

Applying these three factors to several categories of Medicare professional payments, some remarkable inconsistencies emerged.

CATARACT REMOVAL WITH PROSTHETIC LENS REPLACEMENT: this procedure requires the same years of training as cholecystectomy. The procedure itself takes about an hour or less and is performed on an out-patient basis. There is substantially no professional aftercare.

Using the "cholecystectomy index", therefore, cataract surgery with lens replacement is worth less than half of the fee paid for gall-bladder removal. 250.00-300.00 would be ample. Medicare in fact pays 1500.00 or more for this procedure in all areas studied. It is speculated that some ophthalmic surgeons are billing up to 40,000 a week for what is, in fact, minor surgery. If the fee for cataract surgery were reduced to a reasonable level, Medicare would save over 1000.00 per procedure: total savings would be approximately 600,000,000 per year. This is a startling figure, but then, Medicare is now paying startling fees.

INSERTION OF PERMANENT PACEMAKER: This is now a relatively simple procedure, requiring an hour or less. It is frequently performed by cardiologists with no specialized surgical training. The risk is very small, and no more than twenty-four hours of hospitalization are required. Using the cholecystectomy index, again, 250.00-300.00 would be an adequate fee: in fact Medicare pays 1500.00 or more in all areas.

Potential savings if the fee were reduced 1200.00 equal about 80,000,000.00.

CORONARY ARTERY BYPASS SURGERY: A few years ago this was a complex, dangerous procedure performed in a few centers by a very few highly skilled surgeons. Now the procedure is commonplace. Cost factors are as follows.

Years of training: seven.

Time of procedure: three hours, average.

Risk: significant (1-10%, depending on category of patient.)

Aftercare: 3 days to a week, often complicated.

All these factors yield a reasonable fee of 2000.00, on the basis of the cholecystectomy index. In fact, Medicare pays as much as 6000.00 in some areas, and pays well over 2000.00 evrywhere.

We have not yet been able to determine the total number of coronary artery bypass procedure paid for annually by Medicare but an educated guess suggests that by reducing teh overall fee to 2000.00 the savings would run well over 500,000,000.00.

Please note that these are potential savings in only three selected procedures, and note further that these are realistic figures that would still provide adequate professional compensation on any rational basis.

ERRATIC PAYMENT SCHEDULES: in the course of our study it has become apparent that fee schedules vary in an irrational manner in the various Medicare areas. The fees paid for the specific procedures listed above vary from one part of the country by several hundred percent- far beyond anything one might expect from simple differences in cost of living.

More to the point, the relation of the fees to each other varies in an equally erratic manner in the various Medicare areas. If a specific procedure is worth twice as much as another in one area, it should be worth twice as much anywhere, but such is not the case. The random variation in the relation of the various Medicare fees to each other indicates that there has been no realistic assessment of values or costs in each category-rather there has been a hodge-podge of casual acceptance of fees that are often irrational in the first place.

INVASION VERSUS CARE: in general Medicare fees have echoed a national pattern in paying too much for procedures and too little for medical care. The pediatrician who comes to see a crticial child in the early morning hours is paid less than a surgeon who performs some trivial procedure. When a cardiologist passes a Swan-Ganz catheter into the heart- a simple procedure that rarely takes more than twenty minutes- he is paid 200.00- more than he would make in four or five hours of hard, skilled, clinical work when he establishes a diagnoses or intitiates treatment. The overpayment of invasive procedures and the underpayment of "cognitive" skills is skewing U.S. medicine away from thoughful patient care and toward hasty and often harmful instrumentation. Secretary Bowen missed the whole point of this issue when he addressed the annual meeting of the American Academy of Family Physicians last year. He stated that changing the Medicare fee schedule to reward cognitive services and to reduce the overpayments for invasive procedures would "discourage innovation" and "put a damper on competition".

One can only conclude Dr. Bowen is hopelessly out of touch with medical reality or is under enormous pressure from self-serving surgical interests.

"Innovation"-i.e. research- is carried on in academic and other institutional centers by salaried physicians who have no financial involvement with a fee structure. Reducing exorbitant surgical fees would have no effect whatsoever on "innovation." About the only innovation to expected from the physicians generating the enormous sums abovementioned would be in the realm of billing or promotion: they certainly don't carry on reserch. The notion that reducing exorbitant fees would stifle competition is irrational. There isn't any fee competition in the Medicare world: surgeons will take the highest fee Medicare will give them and they have no incentive to charge less.

Both these comments cast the gravest doubts on Dr. Bowen's capacity in this specific setting.

SOLUTION: 1: stop the production of arcane mathematical formulae by administrators, statisticians, and accountants:

these have only perpetuated the abuses listed above. Some of the regulations promulgated have defied the best efforts of highly trained, skilled administrators to elucidate them.

2: assemble a committee of highly skilled physicians who are dedicated to the public interest and knowledgeable about appropriatentess of medical performance and funding.

3: ask these physicians to function as "dollar-a-year" men, to set appropriate fees in the several Medicare categories using some simple rational approach such as that outlined above.

4. begin implementing fee changes at once, as soon as reasonable fees are evolved for each procedure. There's no need to wait for total, across-the-board changes: begin with one fee at a time. Within two weeks enough changes can be implemented to effect the billion dollars of savings that were set as a goal last year.

Expensive, Complicated organizations and proceedings are not needed. The Harvard-Medicare consultative group now functioning may or may not produce something useful in two years. In realistic fact, the major savings possible can be put in hand in about two weeks. The present system of inappropriate fee schedules is a standing joke among the medical profession. It has only been perpetuated because there are no experienced physicians with the necessary professional background to make realistic judgements in the Medicare-HCFA hierarchy. Physicians who have spent their life in administration simply aren't equipped to make these judgements. There is a substantial number of us who are so equipped and so motivated. Please use our talents. We can save the U.S.taxpayer some billions of dollars, and we'll do it for nothing.

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